SERFF Tracking Number:	*AMFA-126939026*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*47614*
Company Tracking Number:	*ARKANSAS BAR ASSOCIATION*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Arkansas Bar Association*		
Project Name/Number:	*Arkansas Bar Association/Arkansas Bar Association*		

Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: Arkansas Bar Association	SERFF Tr Num: AMFA-126939026	State: Arkansas
TOI: H10G Group Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 47614
Sub-TOI: H10G.000 Health - Dental	Co Tr Num: ARKANSAS BAR ASSOCIATION	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Janis Landon	Disposition Date: 12/30/2010
	Date Submitted: 12/30/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Arkansas Bar Association	Status of Filing in Domicile:
Project Number: Arkansas Bar Association	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Group Market Type: Association	Overall Rate Impact:
Filing Status Changed: 12/30/2010	
State Status Changed: 12/30/2010	Deemer Date:
Created By: Janis Landon	Submitted By: Janis Landon

Corresponding Filing Tracking Number:

Filing Description:

RE: Request for Review –State Association Group
Arkansas Bar Association

Dear Sir/Madam:

Ameritas Life Insurance Corp. (“Ameritas”) has recently issued a group policy providing dental and eye care benefits to the members of the Arkansas Bar Association (ABA), situsedin Arkansas. The association will potentially have members in your state.

SERFF Tracking Number:	*AMFA-126939026*	*State:*	*Arkansas*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Arkansas Bar Association*		
Project Name/Number:	*Arkansas Bar Association/Arkansas Bar Association*		

Therefore, we are requesting the Department's approval of this association group as a state group. Enclosed are the required certification forms and the association documents.

You may locate additional information on the following website http://www.arkbar.com.

The ABA is a voluntary, statewide organization with more than 5,000 members. Among its purposes are the advancement of the administration of justice and the fostering among its members of high ideals of integrity, learning and public service.

The ABA, established in 1898, is a voluntary bar association with 5,000 attorney members. For over a century, the Association has been enhancing the lives of Arkansas citizens, the operation of the state's judicial system, reform of state laws, and the professionalism of lawyers.

The activities of the ABA are accomplished through its volunteer members, which are organized among committees and sections and supported by a staff of ten.

The officers of the Association include a President, President-Elect, Secretary, Treasurer, and Chair of the Board of Governors. Each officer's one-year term begins at the conclusion of the Association's Annual Meeting. The Association is governed by a House of Delegates and Board of Governors (idea for HOD & BOG page-- have links for meeting reports). The Young Lawyers Section consists of all members of the Association under the age of 36 or who have been admitted to the practice of law five years or less.

The purposes of the Arkansas Bar Association include the following:
•Advance the Administration of Justice.
•Foster and maintain on the part of attorneys high ideals of integrity, learning, competence and public service, and high standards of conduct.
•Encourage the legal profession and its individual members to perform more effectively and efficiently their responsibilities in the public interest.
•Conduct a program of continuing legal education for attorneys.
•Provide a forum for the discussion of subjects pertaining to the practice of law.
•Improve the judicial and legal process, and advance law and order.
•Encourage practices that improve the honor and dignity of the legal profession.

The current address for this out-of-state group is:
Arkansas Bar Association
2224 Cottondale Lane
Little Rock, AR 72202

SERFF Tracking Number:	*AMFA-126939026*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*47614*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Arkansas Bar Association*		
Project Name/Number:	*Arkansas Bar Association/Arkansas Bar Association*		

Thank you for your review of this filing. If you need anything additional, please feel free to contact me at 800-745-1112, ext. 82444, FAX 402-309-2573 or email jlandon@ameritas.com.

Sincerely,

Janis Landon
Senior Contract Analyst

Company and Contact

Filing Contact Information

Janis Landon, Senior Contract Analyst	jlandon@ameritas.com
475 Fallbrook Blvd.	800-745-1112 [Phone] 82444 [Ext]
Lincoln, NE 68521	402-309-2573 [FAX]

Filing Company Information

Ameritas Life Insurance Corp.	CoCode: 61301	State of Domicile: Nebraska
5900 O Street	Group Code: 943	Company Type:
P O Box 81889	Group Name:	State ID Number:
Lincoln, NE 68501-1889	FEIN Number: 47-0098400	
(800) 756-1112 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	$50.00	12/30/2010	43318550

SERFF Tracking Number:	*AMFA-126939026*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*47614*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Arkansas Bar Association*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/30/2010	12/30/2010

SERFF Tracking Number:	*AMFA-126939026*	*State:*	*Arkansas*
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Disposition

Disposition Date: 12/30/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-126939026*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	No
Supporting Document	Application	Approved-Closed	No
Supporting Document	Constitution & Bylaws	Approved-Closed	No
Supporting Document	Group Policy sitused in Arkansas	Approved-Closed	No
Supporting Document	Membership Information	Approved-Closed	No
Supporting Document	Group Dental and Eye Care Certificates	Approved-Closed	No

SERFF Tracking Number:	*AMFA-126939026*	*State:*	*Arkansas*
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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/30/2010

Comments:

Attachment:

AR Readability .pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	12/30/2010

Comments:

Attachment:

Signed Application.pdf

		Item Status:	Status Date:
Satisfied - Item:	Constitution & Bylaws	Approved-Closed	12/30/2010

Comments:

Attachment:

ABA Constitution and Bylaws.pdf

		Item Status:	Status Date:
Satisfied - Item:	Group Policy situsued in Arkansas	Approved-Closed	12/30/2010

Comments:

Attachment:

010-350682EP.pdf

		Item Status:	Status Date:
Satisfied - Item:	Membership Information	Approved-Closed	12/30/2010

Comments:

SERFF Tracking Number:	*AMFA-126939026*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*47614*
Company Tracking Number:	*ARKANSAS BAR ASSOCIATION*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Arkansas Bar Association*		
Project Name/Number:	*Arkansas Bar Association/Arkansas Bar Association*		

Attachments:

ABA Media Kit.pdf

Membership Form 2010.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Group Dental and Eye Care Certificates	Approved-Closed	12/30/2010

Comments:

The Department approved an Arkansas specific certificate under SERT-65HRLM571. Since this approval, insert pages (various forms) were filed and approved under SERFF #'s:

AMFA-125485830

AMFA-126650717

AMFA-126147025

AMFA-126799268

AMFA-126796845

AMFA-126177337

AMFA-126555885

Attachments:

010-350682C1_DENTAL.pdf

010-350682C2_EYECARE.pdf

STATE OF ARKANSAS

CERTIFICATE OF READABILITY

INSURER: Ameritas Life Insurance Corp.

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

FORM NO:	FLESCH SCORE:	FORM NAME:
9000 Policy Rev. 03-08	50, with policy/certificate	Policy Cover

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: Gail M. Garcia

Digitally signed by Gail M. Garcia
DN: cn=Gail M. Garcia, o=Ameritas Life Insurance Co, ou=Group Compliance, email=ggarcia@ameritas.com, c=US
Date: 2010.12.08 11:13:43 -06'00'

TYPED NAME: Gail M. Garcia
TITLE: Vice President - Group Compliance

DATE: 12/08/10

application

See reverse side for additional information.

AMERITAS LIFE INSURANCE CORP.
Lincoln, NE

for association group dental and/or vision insurance

1. **Applicant's Legal Name** Arkansas Bar Association

2.

P.O. Box / ZIP Code

2224 Cottondale Ln
Street Address

Little Rock AR 72202
City / State / ZIP

501-375-4605 501-375-3961
Phone No. Fax No.

E-mail Address Tax I.D. No.

3. **What is the type and occupational nature of the association?** (Please provide copy of association bylaws.)
   - I Trade
   - I Professional Attorney
   - I Other

4. **Eligibility**
   - Total number of eligible employees .....
   - Employees in waiting period .....

5. **Are any Association chapters, classes of members or locations excluded?** ..... I Yes I No
   Are domestic partners included? ..... I Yes I No
   Are retirees included? ..... I Yes I No
   (If yes, please use reverse side for explanation.)

6. **Are employees of Association members or Non-Association members eligible to participate?** ..... I Yes I No
   (If yes, please use reverse side to list name and location.)

7. **Who is responsible for eligibility verification?**
   I Association Office I Broker/TPA
   I Other

8. **The following coverages are applied for:**
   Employee & Dependents Benefits
   I Dental I Orthodontia I Eye Care
   I Other
   Employee Only Benefits
   I Dental I Orthodontia I Eye Care
   I Other

9. **Member Participation/Contribution**
   I Members pay 100% of premiums
   I Premiums paid by Association dues
   I Other:

10. **Dependent Participation/Contribution**
    I Members pay 100% of premiums
    I Premiums paid by Association dues
    I Other:

11. **Waiting Period**
    _____ for those employed on or before the policy effective date.
    _____ for those employed after the new policy effective date.

12. **Effective Date and Termination Date**
    I Immediate
    I First of Month Effective date / End of Month Termination date
    I Other

13. **Premium Payment Mode (In advance)**
    I Monthly I Quarterly I Semi-Annual I Annual

14. **If a policy effective date is other than first of the month, is a first-of-the-month premium due date desired?** ..... I Yes I No

15. **Billing Options**
    I Home Office
    I Third-Party Administration (TPA must be approved by us.)

    Contact Name

    Title

    Street Address

    City / State / ZIP

    Phone No. Fax No.

    E-mail Address

16. **Policy and Certificate Delivery (select one)**
    A. **eCert*/ePolicy** (*generic cert, non-personalized)
    I via PDF format sent via e-mail to:

    I via eService and member portal
    B. **Paper policy/personalized certificates**
    I Initial employees only
    I Subsequently added employees
    Note: eCert will be available on member portal for all members.

17. Insurance requested on this application will replace the coverage(s) checked.

Coverages: I Dental I Orthodontia I Eye Care

I Other _____

Name of Current Carrier _____

Policy No. _____

I Coverage applied for is replacing comparable coverage now or previously in force with another carrier.

I It is intended that the insurance coverage applied for be in addition to, supplemented by, or supplemental to any similar coverage now in force, or to be in force, with this or any other carrier.

_____ _____

Termination Date Original Effective date

Item 5: Exclusions

a. Classes, include reason for exclusion.

_____

_____

b. Locations, if location is different from applicant's, list city and state.

_____

_____

Plan Design and Proposed Rates: _____

_____

_____

Additional Remarks: _____

_____

_____

Agreements

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., group insurance at the Company's rates and under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

Statements

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (See state-specific statements.) • **Note for California Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. For group policies issued, amended, delivered or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents. • **Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts for information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. • **Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. • **Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law. • **Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. • **Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. • **Note for New Mexico Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. • **Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I **If you do not want your company name used by Ameritas Life Insurance Corp. in our effort to recruit PPO providers, check this box.**

Signed at: City Little Rock State AR Date 12-8-10

Signed by: (Policyholder Representative)

Printed name and title Lorrie Payne, Associate Director

Signature Lorrie Payne

Soliciting Agent: I understand and agree that if I'm not already appointed with Ameritas Life Insurance Corp., I must apply to and be appointed with Ameritas before I present this product to any client.

Printed Name Michael Crow For FL agents only, provide FL license # _____

Signature Michael Crow

The policy provides dental and/or vision benefits only. Review your policy carefully.

Was a binder check received? I Yes I No If yes, then amount $_____.

Check received by (agent) _____ **Authorized by** (policyholder) _____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AMERITAS LIFE INSURANCE CORP.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Constitution & By-Laws of the Arkansas Bar Association

Rules of Procedure of the House of Delegates

As of January 23, 2010

Constitution of the Arkansas Bar Association

As amended through January 23, 2010

Article I

Name and Purposes

This Association shall be known as the Arkansas Bar Association. Its purposes, which are to be exercised in the public interest, are as follows: To advance the administration of justice according to law; to aid the courts in carrying on the administration of justice; to foster and maintain on the part of those engaged in the practice of law high ideals of integrity, learning, competence and public service, and high standards of conduct; to encourage cordial relations among lawyers; to provide a forum for the discussion of subjects pertaining to the practice of law and related subjects; to carry on a program of continuing legal education among lawyers; to carry on a continuing program of legal research in technical fields of law, practice, and procedure, and to make reports and recommendations thereon; to improve the judicial and legal process, and the science of jurisprudence, and to advance law and order; to encourage the formation and activities of autonomous local, county and district bar associations; to encourage practices that would advance and improve the honor and dignity of the legal profession and to encourage the legal profession and its individual members to perform and to discharge more effectively and efficiently their responsibilities in the public interest.

Article II

Membership

Section 1. **Regular Membership.** All persons licensed to practice before the Supreme Court of Arkansas who have been or are elected to membership and who pay dues as provided by the By-Laws of the Association are regular members and shall be voting members of the Association.

Section 2. **Associate Members.** Any person admitted to practice before any court of final jurisdiction in any state of the United States, and who is not admitted to practice law in Arkansas, but who is either a resident of Arkansas or is a full time employee of a business organization which regularly does business within Arkansas may be granted Associate Membership in this Association and may vote in Association elections and participate fully in the activities and committee work of the Association but may not hold office or membership in the House of Delegates, or the Board of Governors. Associate Members shall pay the same membership dues as other members and shall be eligible for the same benefits of the Association except as provided in this Constitution.

Section 3. **Law Student Membership.** Any law student in good standing at any accredited law school in the state of Arkansas or a resident of the state of Arkansas attending an accredited law school outside the state of Arkansas shall be eligible for membership in the Law Student Section of the Association with all the rights and privileges of membership except the right to vote and to hold Association elective office.

Section 4. **Termination of Membership.** A member not in default in payment of dues and against whom no complaint or charge by the Association is pending may at any time file his or her resignation in writing with the Secretary, and it shall become effective as of the date it is filed and accepted by the Board of Governors. The Board of Governors, subject to approval of the House of Delegates, may reinstate any member upon written application for reinstatement. The House of Delegates may censure, suspend, or expel any member for cause after notice and hearing.

Article III

Officers

Section 1. **Title and Term of Office.** The officers of the Association shall be a President, a President-Elect, a Secretary, a Treasurer, and Chair of the Board of Governors who shall hold office for one year and until their

successors are selected. Their terms of office shall begin at the conclusion of each Annual Meeting of the Association following their election or selection.

Section 2. **Election of President-Elect.** The President-Elect shall be elected by a ballot of the entire membership of the Association. Nominations shall be made by petition signed by at least seventy-five (75) Association members. The petition signers must include at least twenty-five (25) regular Association members residing in each of the three State Bar Districts as defined in this Constitution. Nominating petitions shall be filed with the Secretary at the office of the Association no later than October 31. After the close of nominations and in the event of a contest for the office of President-Elect, each candidate may provide a one page statement which shall be included with the ballot. Not more than 20 days after October 31, the Secretary shall mail to each voting member of the Association a ballot on which the names of the candidates are listed in alphabetical order. To be counted, ballots must be received by the Secretary at the office of the Association no later than December 15. The balloting shall be conducted in such a way as to preserve its secrecy, but to assure that only Association members cast votes. Counting of the ballots shall be under the supervision of the Secretary who shall be assisted by between two and five tellers designated by each of the candidates. The candidate receiving the highest number of votes cast in the election immediately becomes the President-Elect Designee, and succeeds to the office of President-Elect at the conclusion of the next Annual Meeting of the Association.

Section 3. **State Bar Districts.** For the purpose of nominating and electing a President-Elect, the state shall be divided into three State Bar districts: A, B, and C. The counties included in each State Bar district shall be determined as provided in Article IV, Section 4. Nominations shall be made from the A, B and C Districts in rotation.

Section 4. **Eligibility of President-Elect.** Only regular members residing in the currently eligible district and nominated as provided in Article III, Section 2, shall be eligible for nomination and election to the office of President-Elect. In the event there shall be only one nominee for the office of the President-Elect and that nominee should die or otherwise be disqualified before the election, the Board of Governors shall call a new election for the

office of President-Elect. Deadlines for nominations and voting by mail shall be fixed as nearly as possible in accordance with the schedule set forth in Section 2 of this article.

If the county in which the President-Elect Designee, the President-Elect, or the President resides is moved from one State Bar District to another as a result of a reorganization of State Bar Districts as provided for in Article IV, Section 4, after that person has been elected, that person shall be considered as residing in his or her original State Bar District until that person becomes Immediate Past President.

Both the President-Elect and President must remain a resident of Arkansas during their terms in office. Should either become a non-resident, the Board of Governors shall declare his or her office vacant.

Section 5. **Succession to Presidency.** The President-Elect shall succeed to the office of President at the end of his or her term without further election.

Section 6. **Vacancies.** The By-Laws shall provide for succession or replacement in the event the office of President-Elect Designee, President-Elect, or President becomes vacant through the death, inability to serve, resignation, or other disqualification of the incumbent.

Section 7. **Secretary and Treasurer.** A Secretary and a Treasurer shall each be elected by a majority of those present and voting at the regular meeting of the House of Delegates held during the Association's Annual Meeting. Any vacancy in this office shall be filled by majority vote of the Board of Governors.

Article IV

House of Delegates

Section 1. **Governance of the Association.** This Association shall be governed by a House of Delegates and a Board of Governors. The House

of Delegates shall be the Association's policy making body. Subject to the superintending authority of the House of Delegates, the Board of Governors shall conduct the business and management of the Association. The House of Delegates may further define policy, business, and management and may reserve decisions to itself. Any action taken by the Board of Governors shall be subject to repeal or modification by the House of Delegates unless the passage of time makes repeal or modification inequitable, inappropriate, or impracticable.

Section 2. **Membership.** The Membership of the House of Delegates shall consist of 81 regular members of the Association proportionately representing the Delegate Districts as set forth in Section 4. The Delegates from each Delegate District shall reside within a particular Delegate District and be elected by members of the Association residing within that District. The President, President-Elect, Secretary, Treasurer, Immediate Past President, Chair of the Board of Governors, and Chair of the Young Lawyers' Section shall be ex-officio members of the House of Delegates with the right to vote and to participate in all proceedings. The President of the Association or, in his or her absence, the President-Elect, shall preside over all meetings of the House of Delegates and shall vote only if the Delegates are equally divided.

Section 3. **Election of Delegates**. Three (3) regular members of the Association residing within a Delegate District may nominate an Association member within that District for the office of Delegate by filing a petition in writing with the Secretary at the office of the Association no later than March 31. Not more than fifteen (15) days after March 31, the Secretary shall mail to each voting member of the Association residing within the Delegate District a ballot on which the names of the candidates are listed in alphabetical order. To be counted, the ballots must be received by the Secretary at the office of the Association no later than May 18.

The balloting shall be conducted in such a way as to preserve its secrecy, but to assure that only Association members cast votes. Counting of the ballots shall be under the supervision of the Secretary who shall be assisted by such persons as the Secretary designates. The results of balloting from each Delegate District shall be certified by the Secretary to

the House of Delegates at the meeting held during the Association's Annual Meeting. If the number of nominees does not exceed the number of Delegates to be elected from a particular Delegate District, such nominee shall be declared elected by the Secretary without the necessity of a ballot. If the number of nominees does exceed the number to be elected, the nominee receiving the highest number of votes from any Delegate District shall be elected to the office of Delegate, and, in the event of a tie, the winner shall be determined by the toss of a coin.

In any election to the House of Delegates in which more than one delegate is to be elected from a particular Delegate District, and the number of nominees exceeds the number of Delegates to be elected, the nominees shall be listed alphabetically by the Secretary on a single ballot which shall contain an instruction to the member voting to designate by appropriate mark those nominees for whom he or she wishes to vote so long as the number of marks does not exceed the number of Delegate positions to be elected from the District; those nominees receiving the highest number of votes shall be elected to the office of Delegate, and, in the event of a tie, the winner shall be determined by the toss of a coin.

Section 4. **Delegate Districts.** Within each State Bar District there shall be Delegate Districts, with the number of delegates to be elected from each Delegate District as set forth below, until changed as provided herein.

A. **District A:**
- A-1 Benton County - five (5) delegates;
- A-2 Washington County - eleven (11) delegates;
- A-3 Crawford, Sebastian, Franklin & Johnson Counties - five (5)delegates;
- A-4 Polk, Scott, Logan & Yell Counties - one (1) delegate;
- A-5 Madison, Carroll, Boone & Newton Counties - one (1) delegate;
- A-6 Pope County - one (1) delegate;
- A-7 Marion, Baxter, Fulton, Searcy, Stone & Izard Counties - two (2) delegates.

B. **District B:**
- B Pulaski County - thirty (30) delegates.

C. **District C:**

C-1 Greene, Clay, Lawrence & Randolph Counties - one (1) delegate;
C-2 Jackson, Independence, & Sharp Counties - one (1) delegate;
C-3 Craighead County - three(3)delegates;
C-4 Poinsett & Mississippi County - one (1) delegate;
C-5 Crittenden, Cross, St. Francis, Woodruff, White & Cleburne Counties - three (3) delegates;
C-6 Van Buren & Faulkner Counties - two (2) delegates;
C-7 Lonoke, Prairie & Monroe Counties one (1) delegate;
C-8 Grant, Jefferson, Arkansas, Lincoln, Phillips & Lee Counties - three (3) delegates;
C-9 Dallas, Cleveland, Ouachita, Calhoun, Bradley, Drew, Ashley, Desha, Chicot, Columbia & Union Counties - three (3) delegates;
C-10 Miller County - two (2)delegates;
C-11 Montgomery, Howard, Pike, Clark, Sevier, Little River, Hempstead, Nevada & Lafayette Counties - two (2)delegates;
C-12 Garland County - one (1) delegate;
C-13 Saline & Hot Spring Counties - two (2)delegates.

At least once every ten (10) years following the 2000 Annual Meeting, the House of Delegates shall review the organization of Delegate Districts and shall adopt a new organization of the Delegate Districts as necessary to achieve more equitable representation of the members of this Association in the House of Delegates. This review and possible reorganization may include revision of the number and composition of the State Bar Districts as necessary to achieve more equitable representation of Association members in the House of Delegates. Provided that the membership of this Association shall be given notice, through a regular Association publication or individual written communication, of the proposed reorganization at least 30 days prior to the meeting at which the House of Delegates will consider the reorganization plan.

Section 5. **Terms of Office.** Members elected to the House of Delegates shall serve for a term of three (3) years and shall assume office at the beginning of the Association's Annual Meeting held following their election. The term will end at the conclusion of the Association's Annual Meeting three (3) years later. Therefore, the House of Delegates will consist of approximately one-third (1/3) more delegates during the regular

meeting held during the Association's Annual Meeting than at other meetings of the House of Delegates.

Section 6. **Vacancies.** A vacancy shall exist in the House of Delegates due to lack of a nominee or to a Delegate's death, resignation, succeeding to ex-officio membership, ceasing to be an Association member or ceasing to reside in the District from which he or she was elected or other disqualification. The President shall appoint a member who resides in the affected District to serve the remainder of the unexpired term, unless the vacancy is due to lack of a nominee. If the vacancy is due to lack of a nominee, the President shall wait to fill the vacancy until the members residing in the affected District have been given a final opportunity to nominate and elect the Delegate. The Secretary shall promptly send written notice of the existence of the vacancy to the members of the Association residing within the affected District, and, in such notice shall further state (a) that the vacancy shall be filled by special election, (b) that nominations shall be made by written petition of three (3) members of the Association residing within the affected District filed with the Secretary within twenty-five (25) days of the date of the notice, (c) that the special election shall be by written ballot tabulated within twenty-five (25) days following the closing of nominations and (d) that the person elected to fill the vacancy shall serve for the remainder of the term for which originally there was no nominee. The preparation of the ballot and the certification of the result of any special election shall be conducted by the Secretary in the manner provided in Section 3 of this Article.

A vacancy shall exist in the House of Delegates whenever a Delegate fails to attend two consecutive regular meetings of the House unless excused by the President of the Association or the Chair of the Board of Governors as provided for in the By-Laws; provided, however, that should the Delegate attend a special meeting between the two regular meetings, such attendance at such special meeting shall be in lieu of attendance at the second regular meeting and will be so counted.

Section 7. **Limitation of Terms.** No delegate shall serve more than six (6) consecutive years as an elected member of the House of Delegates.

Section 8. **Law Student Section Delegates.** Each law school located within the State of Arkansas shall have one Law Student Section Delegate. Each Delegate will be elected annually by the Law Student Section members from the respective law schools. All privileges of the floor, including the right to vote, shall be extended to each such Delegate.

Section 9. **Quorum.** A majority of the voting membership of the House of Delegates shall constitute a quorum for the transaction of business, and any fewer number may adjourn the meeting from time to time until a quorum is secured.

Section 10. **Non-Voting Members.** All privileges of the floor, with the exception of the right to vote, shall be extended to all past presidents of the Association, the President of the Arkansas Bar Foundation, the Association Delegates to the American Bar Association, a member of the Arkansas Judicial Council designated by the Council, and any former member of the House of Delegates who has served at least six years as an elected member of the House.

Section 11. **Rules.** The House of Delegates may adopt rules governing the conduct of its meetings, and, unless otherwise provided, Robert's Rules of Order shall control.

Article V

Board of Governors

Section 1. **Membership.** There shall be a Board of Governors of the Association consisting of ex-officio members, eighteen (18) members elected to the Board from Board of Governors Districts, and three appointed members. Each President-Elect, prior to assuming office, shall appoint one member to the Board of Governors. This appointee shall serve a term of three years beginning with the term of the President-Elect. The President, Immediate Past President, President-Elect, Secretary, Treasurer, and Chair of the Young Lawyer's Section shall be ex officio members of the Board with the right to vote and to participate in all proceedings. The Chair of the Board of Governors shall be an ex-officio member of the Board of Governors; however, the Chair of the Board of

Governors shall vote only if the Board members voting on the question then under consideration are equally divided. Liaison, non-voting members of the Board of Governors may be designated in the By-Laws of the Association.

Section 2. **Election of Members.** The eighteen (18) elected members shall be nominated and elected from Board of Governors Districts established by the House of Delegates for terms of three years each, beginning at the conclusion of the Association's Annual Meeting. The nomination and election process shall follow the same process for election of House of Delegates members except as provided otherwise in this Constitution. If no eligible member is nominated for a Board of Governors position for which an elected term will begin at the next Annual Meeting, the President-Elect shall appoint an eligible member to serve until an election to fill the remaining portion of the term is conducted at the next regular election.

Section 3. **Board of Governors Districts.** To the maximum extent possible consistent with the equitable representation of Association members in the Board of Governors, the Districts shall not overlap State Bar District or county boundaries. Until a future redistricting is accomplished as set forth below, the Board Districts are as follows:

1-BG	Clay, Craighead, Greene, Mississippi Counties - one (1) governor;
2-BG	Cleburne, Independence, Jackson, Jefferson, Lonoke, White, Woodruff Counties - one (1) governor;
3-BG	Arkansas, Ashley, Chicot, Cleveland, Crittenden, Cross, Desha, Lee, Lincoln, Monroe, Phillips, Poinsett, Prairie, St. Francis, Union Counties – one (1) governor;
4-BG	Bradley, Calhoun, Columbia, Drew, Hempstead, Lafayette, Little River, Miller, Nevada, Ouachita Counties - one (1) governor;
5-BG	Garland, Saline, Hot Spring, Grant, Dallas Counties - one (1) governor
6-BG	Benton County- one (1) governor;
7-8 BG	Washington County- two (2) governors;

9-BG	Baxter, Boone, Carroll, Faulkner, Fulton, Izard, Lawrence, Madison, Marion, Newton, Randolf, Searcy, Sharp, Stone, Van Buren Counties - one (1) governor;
10-BG	Sebastian County - one (1) governor;
11-BG	Clark, Conway, Crawford, Franklin, Howard, Johnson, Logan, Montgomery, Perry, Pike, Polk, Pope, Scott, Sever, Yell Counties - one (1) governor;
12-18BG	Pulaski County - seven (7) governors

At least once every ten (10) years following the 2000 Annual Meeting, the House of Delegates shall review the organization of Board of Governors Districts and shall adopt a new organization of the Board Districts as necessary to achieve more equitable representation of the members of this Association in the Board of Governors. This review and possible reorganization may include revision of the number and composition of the State Bar Districts as necessary to achieve more equitable representation of Association members in the Board of Governors. Provided, that the membership of this Association shall be given notice, through a regular Association publication or individual written communication of the proposed reorganization at least 30 days prior to the meeting at which the House of Delegates will consider the reorganization plan.

Section 4. **Qualifications.** The House of Delegates shall establish qualifications for the elected and appointed members of the Board of Governors. Provided, that the qualifications must at a minimum require that the member must have served one year in the House of Delegates or must have been an Association member for seven (7) years by the time of joining the Board.

Section 5. **Limitation of Terms.** No person shall serve more than six (6) consecutive years as an elected member of the Board of Governors.

Section 6 . **Vacancies.** A vacancy on the Board of Governors shall be deemed to exist if a member of the Board shall cease to be a member of this Association or shall cease to be a resident of the Board of Governors District from which elected, shall fail to attend two consecutive meetings of the Board unless excused by the President or Chair of the Board of Governors as provided for in the By-Laws, or shall succeed to an ex-

officio membership on the Board. In the event of a vacancy in the position of any elected member of the Board of Governors due to death, illness, or other disqualification, the President may make an interim appointment for a term lasting until a successor is elected at an election conducted pursuant to Section 2 of this Article. If the vacancy is in an appointed position, said vacancy shall be filled by the President and the appointee shall serve the remainder of the term of office.

Section 7. **Chair.** Each year immediately after taking office, the President shall appoint a member of the Association to serve as chair of the Board of Governors, and the person thus appointed shall so serve until the conclusion of the next Annual Meeting of the Association. It shall be the duty of the chair of the Board of Governors to preside at the meetings of the Board of Governors and to perform such other duties, not inconsistent with this Constitution or with the By-Laws of this Association, that the Board of Governors may prescribe. Whenever during the term for which appointed, there shall be a vacancy in the office of chair of the Board of Governors, the President shall appoint another member of the Association to complete that unexpired term.

Section 8. **Rules.** The Board of Governors may adopt rules governing the conduct of its meetings, and, unless otherwise provided, Robert's Rules of Order shall control.

Section 9. **Quorum.** A majority of the voting membership of the Board of Governors shall constitute a quorum for the transaction of business, and any fewer number may adjourn the meeting from time to time until a quorum is secured.

Section 10. **Minutes and Agenda.** Promptly following each meeting of the Board of Governors, the Secretary of the Association shall prepare and forward a copy of the minutes of that meeting to each member of the Board of Governors, to each member of the House of Delegates, and to each liaison member of the Board of Governors. Prior to each regularly scheduled meeting of the Board of Governors, the Secretary of the Association shall prepare and forward to those same persons a copy of

the tentative agenda for the meeting of the Board of Governors and the date and place at which the meeting will be held.

Section 11. **Executive Committee.** The Board of Governors shall have an Executive Committee composed of the President, the President-Elect, the Secretary, the Treasurer, the Chair of the Young Lawyers Section, and the Chair of the Board of Governors. The President-Elect Designee and the Association's Executive Director shall be non voting ex-officio members of the Committee. The Executive Committee has the authority to make day to day operational and management decisions, subject to modification by the Board of Governors.

Article VI

American Bar Association Delegates

The delegates from this Association to the House of Delegates of the American Bar Association shall be nominated by petition signed by at least seventy-five (75) Association members. The petition signers must include at least twenty-five (25) voting Association members from (residing in) each of the three State Bar Districts. Nominating petitions shall be filed with the Secretary at the office of the Association no later than March 31. Each delegate shall be elected for a two year term by the membership at large in the same manner and at the same time as for the election of the House of Delegate Members. In the event of a vacancy in the position of delegate, a successor, shall be appointed by the President, with approval of the House of Delegates, to serve the remainder of the unexpired term.

Article VII

Meetings

Section 1. **Annual Meeting of the Association.** The Association shall hold an Annual Meeting between May 15 and June 30 unless the House of Delegates, at least one year in advance, sets another date.

Section 2. **House of Delegates Regular Meetings.** A regular meeting of the House of Delegates shall be held during the Association's Annual Meeting. The House shall hold one other regular meeting each year.

Section 3. **House of Delegates Special Meetings.** Special meetings of the House of Delegates may be called by the President of the Association, by the Board of Governors, or by written petition of ten (10) members of the House of Delegates filed with the Secretary of the Association.

Section 4. **Board of Governors Meetings.** The Board of Governors shall have at least three (3) regular meetings each bar year. Special meetings may be called by the President, Board Chair, or on the written petition of seven (7) members of the Board.

Section 5. **Notice of Meetings.** All meetings of the House of Delegates and the regular meetings of the Board of Governors shall be announced to the membership of the Association by the Secretary at least fifteen (15) days prior to the first day of such meeting. Special meetings of the Board of Governors shall be so announced to the maximum extent practicable.

Section 6. **Open Meetings.** All meetings of the House of Delegates and of the Board of Governors shall be open to the membership of the Association.

Article VIII

Notice of Elections

The Secretary at least thirty (30) days prior to the closing of any nomination upon petition, shall notify in writing all Association members who are eligible to sign a petition of nomination, specifying the office to be filled, the date of closing of nominations, and the number of signatures required to effect nomination.

Article IX

Section 1. Any member, committee, or Section of the Association shall be entitled to present Resolutions for consideration by the House of Delegates. Any proposed Resolution shall be in writing and presented to the President of the Association at the offices of the Association at least thirty (30) days prior to a regular or special meeting of the House of Delegates. Notice of the presentation and text of any Resolution to be acted upon by the House of Delegates shall be given by the Secretary to the members of the Association not less than fifteen (15) days prior to the meeting at which such Resolution will be considered.

Section 2. The requirements of this Article as to notice, presentation, and filing of resolutions, may be waived at any meeting of the House of Delegates upon a two-thirds vote of those present and voting; provided, that any resolution approved at a special meeting of the House of Delegates will bind only the House of Delegates unless expressly stated by a two-thirds vote of those present and voting that it is a resolution binding upon the Association. Regardless of the manner of presentation, proposed resolutions may be amended at the meeting in which they are voted upon by majority vote of those present and voting.

Section 3. The President shall appoint annually a Resolutions Committee consisting of five voting members of the Association. All Resolutions not submitted pursuant to Section 2 of this Article shall be referred by the President on presentation to the Resolutions Committee for consideration and report to the House of Delegates for action. All other resolutions shall be similarly referred to the Resolutions Committee if possible for consideration and report to the House of Delegates for action.

Article XIII

Initiative and Referendum

Section 1. **Initiative.** Seventy-five (75) or more members of the Association, including at least twenty-five (25) voting Association members residing in each of the three (3) State Bar Districts, by written and signed petition filed with the Secretary at the office of the Association,

Adoption and Amendment of By-Laws

By-Laws may be adopted, amended or rescinded by the House of Delegates at any meeting by the affirmative vote of a majority of the full number of its elected and ex-officio members, or by the affirmative vote of two-thirds of those present and voting; provided, that written notice of such proposed action is given to each member of the House of Delegates at least thirty (30) days prior to the meeting at which the proposal is to be offered. Upon such adoption, change, amendment or rescission, notice shall be promptly given to each member of the Association by the Secretary.

Article X

Sections and Committees

Section 1. **Establishment and Purposes.** The House of Delegates or the Board of Governors may establish, abolish or modify Sections an Committees of the Association in order to direct and coordinate the program and related activities of the Association.

Section 2. **Section By-Laws.** Each Section shall have by-laws consistent with the Constitution and By-Laws of the Association. The by-laws of any Section shall define the purposes of the Section, and those by-laws or amendments thereto shall become effective when approved by the House of Delegates or the Board of Governors.

Article XI

Professional and Judicial Ethics

The Model Rules of Professional Conduct and the Arkansas Code of Judicial Conduct as promulgated by the Arkansas Supreme Court are hereby adopted by this Association.

Article XII

Resolutions

at any time may initiate and propose any matter, with the exception of amendment of this Constitution, affecting the administration, organization or policy of the Association. In the event the vote on the initiated proposal shall be against the proposal, or regardless of the outcome if the proposal concerns a proposed amendment to the Constitution of the State of Arkansas or the Constitution of the United States, the same may not be thereafter proposed until after the expiration of 12 months immediately following the vote.

Section 2. **Referendum.** Seventy-five (75) or more voting members of the Association, including at least twenty-five (25) members residing in each of the three (3) State Bar Districts, by written and signed petition filed with the Secretary at the office of the Association at any time within thirty (30) days after the adoption, or a majority of the House of Delegates so voting at the meeting in which the matter is adopted, may refer any action of the House of Delegates or of the Board of Governors to the members of the Association to approve or reject.

Section 3. **Notice and Vote.** Within thirty (30) days after an initiated or referred proposal shall have been timely filed with the Secretary at the office of the Association, he or she shall give detailed Notice thereof to the voting membership by mail. Included in such Notice shall be a ballot for each member to cast for or against the initiated or referred matter, and such Notice shall fix a date between fifteen (15) and thirty (30) days from the date such Notice is posted, of the time that all such ballots shall be received by the Secretary in order to be eligible to be counted in the determination thereof. The Secretary or a designee shall keep the returned ballots unopened in a safe container under private lock until the day following the deadline for voting and thereafter together with a committee of three to ten members appointed by the President for this purpose, shall count and tally all votes cast. The committee shall promptly certify the count attested by the Secretary to the President who shall announce the results of such vote to the active members, either by Notice in the next issue of an official Association publication, or by letter. No initiated measure shall be effective unless approved by more than one-half of the votes cast thereon; and no referred measure shall be annulled unless more than one-half of the votes cast thereon vote to annul the same.

Article XIV

Amendment of Constitution

This Constitution may be amended by the affirmative vote of a majority of the members of the Association voting on any duly proposed amendment. Notice of any proposed amendment may be filed by seventy-five (75) voting members of the Association. The petition signers must include at least twenty-five (25) voting Association members residing in each of the three State Bar Districts. The petitions shall be filed with the Secretary by March 31 for a spring election or October 31 for a fall election, and balloting shall be conducted by the Secretary in the manner as provided in Article IV in regard to a spring election and Article III in regard to a fall election.

Article XV

Proposing, Supporting, or Opposing Amending U. S. or Arkansas Constitution

Before the Arkansas Bar Association may propose, sponsor, or cosponsor any measure to amend the Arkansas Constitution which may be considered by the Arkansas General Assembly, which may have been referred by the Arkansas General Assembly for a vote by the people of Arkansas, or which may be the subject of a petition drive to place it on the ballot for a vote by the people of Arkansas, that action must be approved by the House of Delegates by an affirmative vote of three-fourths of those present and voting. Provided, the Association membership must have been sent notice of the potential House action at least 30 days prior to the regular or special meeting. Said notice shall be provided either in one of the Association's regular publications which is received by all members or through a notice sent to all members.

Before the Arkansas Bar Association may support any measure proposed by others to amend the Arkansas Constitution or the United States Constitution, such action must be approved by the House of Delegates by an affirmative vote of three-fourths of those present and

voting. Provided, the Association membership must have been sent notice of the potential House action at least 30 days prior to the regular or special meeting. Said notice shall be provided either in one of the Association's regular publications which is received by all members or through a notice sent to all members. If during a legislative session time does not permit consideration by the House of Delegates, a body established by the By-Laws to consider legislative actions may take a position on behalf of the Association by a three-fourths vote of that body. Any such affirmative vote on a position shall be promptly reported to the members of the House of Delegates. The House of Delegates may disaffirm such a vote by a majority vote of those present and voting.

The House of Delegates or the Board of Governors, on behalf of the Association, may oppose any measure proposed by others to amend the Arkansas Constitution or the United States Constitution by a three-fourths vote of those present and voting. During a legislative session when there is not time for the House of Delegates or the Board of Governors to consider opposing such a measure, then a body established by the By-Laws to consider legislative actions may oppose such a measure on behalf of the Association by a three-fourths vote of the membership of that body.

Article XVI

Miscellaneous Provisions

Section 1. **Calculating Days.** For calculating deadlines and number of days between events and whether to include or exclude weekends and holidays where such calculation is required by this Constitution or by the By-Laws, the Arkansas Bar Association shall follow the provisions of the Arkansas Rules of Civil Procedure.

Section 2. **Meaning of Residence or Residing.** The term "residence" or "residing" as used in this Constitution for the purposes of voting, signing petitions, and holding office refers to the member's principal place of business, provided that, (a) if the member has no principal place of business or has a principal place of business outside Arkansas, residence or residing shall mean the member's place of abode in Arkansas, or (b) if the member has a place of abode in or has his or her principal place of

business in Texarkana, Texas, and the member pays Arkansas instate membership dues, then the member shall be regarded as having a place of residence in Texarkana, Arkansas.

Article XVII

Transition Provision

These amendments shall become effective February 1, 2000 and shall apply to all future reorganizations.

Elected members serving in the House of Delegates or the Executive Council on February 1, 2000, shall continue to serve as members of the House of Delegates or the Board of Governors, respectively. Their terms will expire at the time they would have expired without these Amendments. The size of the House of Delegates and the Board of Governors may thus be exceeded until normal expiration of terms brings the size of the House of Delegates to 81 elected Delegates and the size of the Board of Governors to 18 elected Governors. If a vacancy occurs in a position which does not extend under the amendments or transition provisions it shall not be filed by appointment or special election. The House of Delegates is authorized to adopt any other transition provisions which may be appropriate and consistent with this Constitution as amended.

By-Laws of the
Arkansas Bar Association
(As amended through January 23, 2010)

ARTICLE I
ADMISSION TO MEMBERSHIP

Individuals who meet the membership qualifications and have paid the required dues shall become members of the Association subject to ratification by the Board of Governors.

ARTICLE II
ASSOCIATION DUES

Section I. **VOTING MEMBERS.** Each member shall pay Association dues for each year from July I to June 30 following, payable on July I of each year in advance, in the amount of $210, with the following exceptions:

a. New admittees receive free dues for the balance of the bar year in which they are admitted to the bar, without an application for Association membership, and their dues for the next bar year immediately thereafter are $45; Provided however, if a new admittee is admitted by motion/reciprocity, the new admittee shall receive free dues for the balance of the bar year in which the new admittee is admitted to the bar, without an application for Association membership, but thereafter the new admittee must pay dues in the applicable amount to remain a member.

b. As provided below in section 4, senior members are exempt from the payment of dues;

c. As an alternative to the standard dues of $210, members may elect to use the income scale below to determine the amount of their dues in a particular year, by checking the appropriate income range. "Income" for this purpose is law-related salary, wages or income after deducting office overhead and other ordinary and necessary business expenses but before taxes, FICA, insurance and pension contributions, for the current or immediately preceding year. Individual income range checkoffs are confidential except for designated Association staff.

0-$25,000	$55 dues
25,001-50,000	$100
50,001-75,000	$145
75,001-125,000	$210
over 125,000	$275

d. If a member is a non-resident of the State of Arkansas, and has no regular law practice in Arkansas, the dues are $70.

SUSTAINING MEMBERSHIP. Members admitted to practice are encouraged to become sustaining members by paying an additional $100 per year. The names of

sustaining members shall be published and other appropriate recognition made of these members.

FACULTY GROUP MEMBERSHIP. Law Schools in the State of Arkansas which are accredited by the American Bar Association may purchase, or their faculty may purchase, a group membership in the Arkansas Bar Association. The fee shall be the same amount as is charged for faculty group memberships by the American Bar Association and the other procedures and benefits shall be as similar as practical to those of the American Bar Association. Faculty group members are considered dues paying members for the purpose of determining privileges and benefits. The only section membership which is automatically granted is membership in the Young Lawyers Section for those who are eligible because of age or recent admission to practice.

Section 2. **LAW STUDENT MEMBERS.** Students at law schools in the State of Arkansas which are accredited by the American Bar Association receive a free membership in the Association and its Law Student Section, provided that they are not voting members of the Association. The benefits to which law student members are entitled, such as specific publications and CLE seminars, shall be determined from time to time by the Board of Governors.

Section 3. **PAYMENT, DELINQUENCIES AND REINSTATEMENT.** Any member, except new admittees under Section 1, admitted to the Association after July I of any year shall pay dues in advance on a pro rata basis for the remaining quarters of the year in which admitted. Otherwise, any member failing to pay annual dues by July 1 shall be notified of such delinquency (if still continuing) no later than August 1. If any member fails to pay the annual dues by September 15, said member shall be dropped from membership in the Association. Provided, a member will be given until October 15 to pay annual dues if said member sends the Association President a letter setting forth a good cause for the delay. A member who has been dropped for non-payment of dues will be reinstated on the payment of current annual dues, but shall not be entitled to exercise the right to vote as a member unless annual dues are paid prior to any polling of the membership as provided by the Constitution of this Association.

Section 4. **SENIOR MEMBERSHIP.** Any member of the Association who shall have attained the age of 75 years and who shall have been a member of this Association in good standing for 10 continuous years immediately before attaining the age of 75, upon written application to the Secretary shall thereafter be exempt from the payment of Association dues.

ARTICLE III
OFFICERS

Section I. **DUTIES.** The officers of the Association shall perform the duties usually performed by such officers and such duties as shall be prescribed by the Constitution and By-Laws or by the Board of Governors.

Section 2. **VACANCY- PRESIDENT.** Should a vacancy occur in the office of President, the current President-Elect shall succeed to the office of President if four months or less remain in the President's term. The President-Elect shall succeed to the office of President if more than four months remain in the President's term and the President-Elect is willing to serve the balance of the unexpired term and a full term as President. In the event the President-Elect declines to fill the vacancy, the President-Elect, as acting President, shall promptly call a special meeting of the House of Delegates. The House of Delegates shall then promptly elect a member of the Association currently residing in the bar district affected by the vacancy, to serve the remainder of the President's term. If the President- Elect has declined to fill the vacancy, the President-Elect shall, nevertheless, serve as acting President until the House of Delegates elects a President.

Section 3. **VACANCY- PRESIDENT-ELECT.**

a. **When President-Elect Office Will Remain Vacant.** If the President-Elect becomes President by succeeding to the vacant office of President, the office of President-Elect shall remain vacant until the time the President-Elect Designee becomes President-Elect at the next Annual Meeting.

b. **President-Elect Designee Willing to Become President-Elect Immediately.** Should a vacancy occur in the office of President-Elect (other than by the incumbent's succession to fill the office of President for the unexpired term of a predecessor) if a President-Elect Designee has been elected and is willing to become President-elect immediately and serve as President beginning at the next Annual Meeting, the President-Elect Designee shall become President-Elect. In such event a new President-Elect Designee shall be elected from the District in which the President-Elect who created the vacancy resided. The Board of Governors shall call an election for a new President-Elect Designee and shall determine the schedule and other details for the nomination and election by the Association's members of such new President-Elect Designee. The normal rotation among Districts shall the return with the election of the next President-Elect Designee.

c. **No President-Elect Designee or President-Elect Designee Not Willing to Become President-Elect Immediately.** Should a vacancy occur in the office of President-Elect (other than by the incumbent's succession to fill the office of President for the unexpired term of a predecessor) and if no President-Elect Designee has been elected, or if the President-Elect Designee declines to immediately become President-Elect and if less than four months remain in the President-Elect's term, the President shall promptly call a special meeting of the House of Delegates. The House of Delegates shall then promptly elect a member of the Association currently residing in the bar district affected by the vacancy, to serve the remainder of the President-Elect's term and become President at the next Annual Meeting. If more than four months remain in the President-Elect's term, the Board of Governors shall promptly call an election for a new President-Elect from the same district affected by the vacancy and shall determine the schedule and other details for the nomination and election by the Association's members of such new President-Elect.

Section 4. **VACANCY- PRESIDENT-ELECT DESIGNEE.** Should a vacancy occur in the office of President-Elect Designee (other than by operation of Section 3.b. of the Article), the Board of Governors shall call an election for a new President-Elect Designee from the same district affected by the vacancy and shall determine the schedule and other details for the nomination and election by the Association's members of such new President-Elect Designee.

Section 5. **MISCELLANEOUS MATTERS.**

a. Should it be appropriate, the Board of Governors may appoint a member of the Association currently residing, or having a primary place of business, in the bar district affected by the vacancy to be the acting or interim holder of a vacant office; and

b. In determining the schedule and other details for nomination and election pursuant to this Article, the Board of Governors shall follow, as closely as reasonable, the relevant nomination and election provisions of the Association's Constitution.

Section 6. **NOTICE.** Prior to acting upon a vacancy pursuant to this Article, the Board of Governors shall give notice of the date, location and agenda of its meeting to the membership. Such notice shall be given promptly in the most expeditious manner possible but no less than 10 days prior to such Board of Governors meeting.

Section 7. **VACANCY - APPOINTIVE OFFICES**. Vacancies in any appointive office shall be filled by action of the respective appointing authority.

Section 8. **LAW STUDENT MEMBERS - TERM OF OFFICE.** The terms of members elected by the Law Student Section under Section 7 Article IV of the Constitution shall commence at the beginning of the Annual Meeting in June and they shall serve until the close of the Annual Meeting of the following June at the same time the terms of the regularly elected members of the House of Delegates commence and terminate.

The Deans of the Law Schools that have a Law Student Section which is eligible to have a Delegate will certify to the Secretary of the Association, no less than five days before the Annual Meeting, the name of the student to represent the Law School for the ensuring year.

ARTICLE IV
BOARD OF GOVERNORS

The following persons shall serve as liaison, non-voting members of the Board of Governors: the President-Elect Designee; the Chair of the Legal Education Committee; the President of the Arkansas Bar Foundation; the Association's Delegate to the American Bar Association; the Executive Director of the Association; a member designated for service on the Board by the Arkansas Judicial Council; a member designated for service on the Board by the Arkansas District Judges Council; and the Association Lobbyist.

ARTICLE V
EXECUTIVE DIRECTOR

The Board of Governors may select and may prescribe the duties of an Executive Director and such other personnel as it may deem necessary, who shall hold office at the pleasure of the Board of Governors.

ARTICLE VI
ANNUAL BUDGET

The Board of Governors shall approve the annual budget of the Association.

ARTICLE VII
SECTIONS

Section 1. **SECTIONS DEFINED.** Sections are groups of Association members, chartered by the Board of Governors. Sections are dedicated to the improvement of the quality and understanding of one or more areas of substantive law, one or more areas of law practice, or both. As such all sections are involved in one or more of the following: continuing legal education; publications; professional networking of members with similar interests and substantive law reform. Section membership is open to any Association member in good standing. Sections are self-governing within the framework of this Article.

Section 2. **EXISTING SECTIONS.** As of January 23, 2010, the Association has the following existing sections which shall continue to exist until merged or terminated by the Board of Governors: Administrative Law Section; Agricultural Law Section; Alternative Dispute Resolution Section; Business Law Section; Civil Litigation Section; Construction Law Section; Corporate & In-House Counsel Section; Criminal Law Section; Debtor/Creditor Law Section; Disability Law Section; Elder Law Section; Environmental Law Section; Family Law Section; Financial Institutions Law Section; Government Practice Section; Health Law Section; Intellectual Property Law Section; International & Immigration Law Section; Juvenile Justice and Child Welfare Section; Labor and Employment Law Section; Natural Resources Law Section; Probate & Trust Section; Real Estate Law Section; Securities Law Section; Solo, Small Firm and Practice Management Section; Section of Taxation; Tort Law Section; Workers' Compensation Law Section; and Young Lawyers' Section.

Section 3. **NEW SECTIONS.** New sections may be established and existing sections combined or discontinued or their names changed by the Board of Governors after the proponents of the section have filed with the President a statement setting forth:

(a) The jurisdiction of the section which shall be within the constitutional purposes of the Association and not in conflict with

the jurisdiction of any section, committee or task force whose continuance is contemplated after the section is established

(b) The proposed by-laws of the section, which shall continuously be subject to review and amendment by the Board of Governors; and

(c) A statement of the need for the proposed section, or combination of sections.

Section 4. **MEETINGS, OFFICERS AND SUCCESSION.**

A. Each section shall have an annual meeting which shall take place during the annual meeting of the Association unless a different date is specified in its bylaws. Sections may also hold such other meetings as may be appropriate.

B. Unless its by-laws provide otherwise: (i) each section shall have a chairperson, a vice-chairperson, a secretary and an executive council consisting of six other section members; (ii) section executive council members shall serve staggered terms of three years each with the terms of two executive council members expiring at the end of the annual meeting of the section each year; (iii) the section chairperson, vice-chairperson and secretary shall each serve as such for a one-year term commencing at the end of the annual meeting of the section. Upon petition, the Board of Governors may allow a section officer to serve consecutive terms in the same office.

C. Unless its by-laws provide otherwise, each section shall elect its secretary, and two executive council members before the conclusion of each annual section meeting. The secretary shall then automatically succeed to the office of vice-chairperson in the next year and the vice-chairperson shall likewise automatically succeed to the office of chairperson. Vacancies occurring through death, resignation or otherwise shall be filled by majority vote of the section's executive council.

D. If a section shall fail to elect any officer before the conclusion of its annual meeting, the President of the Association shall appoint that officer or officers subject to ratification by the Board of Governors of the Association.

Section 5. **SECTION POLICY.**

A. All sections shall operate in accordance with Constitution and By-laws of the Association.

B. Each section shall work with the Association's staff to identify and produce appropriate Association CLE programs and shall encourage section members who have the necessary knowledge and expertise to take an active role in providing Association CLE Programs. Each

section shall present or co-present a CLE or other educational project at least once every two years unless waived by the Board of Governors.

C. Each section is encouraged to assist with the identification and production of Association publications, including practice handbooks for members and pamphlets and guides on legal topics for the general public.

D. Prior to the Annual meeting of the Association, each section shall submit a brief report of the activities of the section during the previous twelve months. This report shall be sent to the Association office which will forward a copy to each section member.

E. Sections are encouraged to submit legislative proposals for consideration as part of the Association's Legislative Package.

F. No section may purport to present an official position of the Association without prior approval of the House of Delegates, Board of Governors, or Legislation Committee.

G. All sections shall have a written policy for the handling of section funds.

(1) The officers of each section shall be responsible for preparing an annual budget which shall include annual dues and a payment to the Association for administrative overhead to be determined by the Board of Governors, unless waived by the Board of Governors.

(2) Each section's budget shall be based on projected dues income for the upcoming fiscal year. It shall be submitted to the President of the Association at least 20 days prior to the meeting of the Board of Governors at which it considers the section's budget for the next year.

(3) All section budgets shall be presented to the Board of Governors.

(4) The Board of Governors shall have the right to approve, disapprove or modify all section budgets.

(5) Expenditures for any given year shall not exceed the amount of income for that period, except as provided below.

(6) If for any reason a section proposes to spend more during a fiscal year than its reasonably expected dues income, a written explanation of the reason for the expenditures shall be attached to its budget. If during the course of the fiscal year, a matter arises which would require expenditures not included within the budget of the section, a written request explaining the need for such expenditures shall be presented to the president explaining such need. The president may approve a total of $500 of such expenditures by each section during a fiscal year. Any requests totaling more than $500 will be referred to the Board of Governors.

ARTICLE VIII
COMMITTEES AND TASK FORCES

Section 1. **COMMITTEES.**

A. The Board of Governors, at the request of the Association's President, President-Elect, or upon its own motion, is empowered to create other Committees of the Association to assist in the association's governance, its programs, or otherwise.

B. The Board of Governors shall specify the terms of committee members, any qualifications for committee membership, including, when appropriate, a requirement that committee members be members of the Board of Governors.

C. Unless the Board of Governors provides otherwise, vacancies on committees shall be filled by the President. The President-elect shall appoint a chairperson of each committee who will serve as such during the succeeding Association year.

D. When contemplating appointments to committees and task forces, consideration should be given to the Association's goal of seeking participation which is broadly representative of its membership, geographic and otherwise.

E. The Legislation Committee shall consist of the following nine voting members:

(1) The President and the President-Elect of the Association,

(2) The chair of the Jurisprudence and Law Reform Committee, and

(3) The chair of the Legislation Committee,
all of whom shall serve for the term of the office held;

(4) Two individuals appointed jointly by the President-Elect and President-Elect designee for four year, staggered terms commencing at the close of Annual Meetings in even numbered years, provided that of the two initial appointments in the spring of 2000, one shall be for two years; and

(5) One representative from each of the state Bar Districts who shall be elected by majority vote of all members of the House of Delegates from that District and who shall serve as District Vice-Chair of the legislative action network for the District from which that member is elected. Such elected representatives from state Bar Districts may, but need not be members of the House of Delegates, and in even numbered years such representatives shall be elected at the Annual Meeting of the Association for a term of two years.

(6) The chair of the Legislation Committee shall be appointed by the President-Elect, prior to assuming the office of President at the close of each annual meeting, and shall serve from the adjournment of that meeting until the adjournment of the next

annual meeting following appointment. The Committee may meet in person or by conference telephone call. The vote of a majority of the full Committee shall be necessary in order for the Committee to act upon any proposition. The Chair shall be eligible to vote. The Committee may otherwise make such rules and regulations as it deems appropriate for its own governance.

F. The Legislation Committee's responsibilities are to:

(1) support the Association's Lobbyist in promoting the enactment of bills included in the Legislative Package approved under Article X of these By-Laws;

(2) support the position of the Association on legislation pending before the Arkansas General Assembly; and

(3) consider and decide the position of the Association on legislation which the House of Delegates has not taken official position on and is under consideration or expected to be considered by the Congress of the United States or by the Arkansas Legislature or its interim committees, or on proposed initiated acts. In fulfilling these responsibilities, the Legislation Committee shall:

a. establish and maintain a statewide legislative action network of lawyers who will serve as legislative contacts to advocate the Association's position to legislators, and recruit lawyers to be legislative witnesses in support of the Association's position on legislative proposals; attend committee meetings and legislative sessions when the Lobbyist cannot be present, and perform such other tasks as are reasonably calculated to achieve the Association's Legislative goals.

b. not support any legislation which the House of Delegates has rejected within the immediate past 24 months nor oppose any legislation which the House of Delegates has approved within the past 24 months. It shall have authority to make changes in proposed legislation of the Association which do not materially change the intent or the purpose of such legislation and may take a position for the Association on other legislation and proposed legislation under consideration or expected to be considered by the Congress of the United States or by the Arkansas Legislature or its interim committees. During special sessions, the Committee may sponsor technical corrections to existing law and poll the House of Delegates on substantive matters which have not previously been voted on by the House.

c. not take a position on any legislation unless it would have a direct effect on the practice of law or a significant impact on the administration of justice.

(4) The President of the Arkansas Bar Association, at his or her discretion or upon the request of the Chair of the Legislation Committee, may appoint one or more subject matter experts to assist the Legislation Committee.

(5) Notwithstanding the voting requirements in Article VIII, Section1, E,(6), the Chair of the Legislation Committee may exercise the authority of the Legislation Committee granted in Article VIII, Section 1, F, (3),when the need for prompt action does not allow the convening of the Legislation Committee or polling it by telephone, e-mail, FAX, or other means of communication.

G. The Jurisprudence and Law Reform Committee shall consist of seventeen to eighteen members. The President-Elect, prior to assuming the office of President at the close of each annual meeting, shall appoint one voting member from each State Bar District, who shall serve from the adjournment of that meeting until the adjournment of the third annual meeting following appointment. The President-Elect shall also appoint two additional members for three year terms, regardless of the State Bar District in which said members reside, and appoint a chair of the committee who may or may not be one of the other members of the committee. The Chair of the Legislation Committee and the Association's Lobbyist shall be non-voting, ex-officio members of the committee.

H. The Jurisprudence and Law Reform Committee's responsibilities are to consider and report concerning all matters of jurisprudence and procedure including reforms of the substantive law and improvement in practice and in administration of the Courts, and such other related matters as may be referred to it by the House of Delegates.

I. Committees, including those in existence as of the adoption of this bylaw, shall continue to exist, from year to year, until terminated by the Board of Governors, except that any change in the Jurisprudence and Law Reform Committee and the Legislation Committee shall require amendment of these By-Laws.

J. House Advisory Committee to President: The President, with the consent of the House Advisory Committee to the President, shall have full power and authority to consider and decide the position of the

Association on legislation or federal regulatory matters on which the House of Delegates has not taken official position and is under consideration or expected to be considered by the Congress of the United States. Further, the President, with the consent of the House Advisory Committee to the President, shall have full power and authority to state the policy position of the Association when it is impractical to convene a meeting of the House of Delegates in time to consider and decide the position of the Association in a time sensitive matter having a direct effect on the practice of law or a significant impact on the administration of justice.

(1). Neither the President nor the House Advisory Committee to the President shall support any legislation or federal regulatory matter which the House of Delegates has rejected within the immediate past 24 months nor oppose any legislation which the House of Delegates has approved with the past 24 months.

(2). Neither the President nor the House Advisory Committee to the President shall take a position on any legislation or federal regulatory matter unless it would have a direct effect on the practice of law or a significant impact on the administration of justice.

(3). The President and the House Advisory Committee to the President may meet in person, by conference telephone call, email, or other electronic means as is most practicable under the circumstances. The vote of a majority of the full Committee shall be necessary in order for the Committee to act upon any proposition. The President shall be eligible to vote.

(4). The House Advisory Committee to the President shall consist of the following ten (10) voting members:

a. The President, President-Elect and Immediate Past President;
b. The Chair of the Board of Governors;
c. Six members selected by the House of Delegates.

(5). The House Advisory Committee to the President shall also consist of four (4) non-voting ex-officio members:

a. The President-Elect Designee;
b. The chair of the Young Lawyers Section;
c. The Secretary of the Association; and
d. The Executive Director.

(6). The House of Delegates shall elect its first six member representatives at the Annual meeting in June 2010.

a. Each bar district shall elect two members. The term of service, except for the Bar Year 2010-2011 shall be two years.
b. At the 2010 Annual meeting, the Bar Districts shall elect two members, one to serve one year and one to serve a two year term. Commencing with the 2011 Annual meeting and annually thereafter the Bar Districts shall elect one member who will serve a two year term.
c. To be eligible for election the member must be a sitting or tenured Delegate.

(7). The President of the Association shall serve as chair of the House Advisory Committee to the President and decide on each occasion the structure of the meeting, whether by telephone conference, in person, or by any practical electronic means. If feasible the President may give the House of Delegates advance notice of a meeting and include the current composition of the committee and their email addresses.

(8). The President of the Association shall notify the full House of Delegates as soon as possible of the substance of all meetings of the committee, regardless of whether any action was taken. Any action take by the House Advisory Committee to the President shall be subject to affirmation, repeal, or modification by the House of Delegates unless the passage of time makes repeal or modification inequitable, inappropriate, or impracticable.

Section 2. **TASK FORCES.**

A. The Board of Governors, at the request of the Association's President, President-Elect or upon its own motion, is also empowered to create one or more task forces to accomplish specific tasks.
B. Unless the Board of Governors provides otherwise, members of task forces and their chairpersons shall likewise be appointed by the President or President-Elect upon the terms and under the conditions set forth by the Board of Governors.
C. A task force shall cease to exist when the Board of Governors determines that the task for which it was formed has been completed or should be abandoned, or otherwise that the task force is no longer needed.

Section 3. **REVIEW.** No action or recommended action of any committee or task force shall be considered the official act of the Association until such action or recommendation shall first have been presented to and approved by the Board of Governors. The Board of Governors may refer such matters to the House of

Delegates for final action. The reports of all committees and task forces shall be made at least annually to the Board of Governors.

Section 4. **COMMITTEE OF PAST PRESIDENTS.** There shall also be a committee of past presidents consisting of those who have served as President of the Association. This Committee shall serve as an advisory committee, and shall make such investigation, studies, recommendations and reports and render such advisory opinions as may be requested of the Committee by the Board of Governors or by the President.

ARTICLE IX
FISCAL YEAR AND ANNUAL AUDIT

The fiscal year of the Association shall be July 1 through June 30, effective January 1, 2010. The books of the Association shall be audited annually by an independent certified public accountant hired by the Finance Committee. The Treasurer shall present the annual audit to the Finance Committee for its review and report the actions required of the Association as a result of the audit to both the Board of Governors and House of Delegates at their next meetings.

ARTICLE X
PREPARATION OF THE LEGISLATIVE PACKAGE

Section I. The Legislative package of Bills to be presented by the Association to the Legislature shall not consist of more than 10 separate bills.

Section 2. Before a bill is allowed to become a part of the package it must receive an affirmative vote of two-thirds of the members of the House of Delegates present and voting on the proposed legislation, either at a regular session of the House or a Special Session called for that purpose.

Section 3. If the exigency of the circumstances requires it, an affirmative vote of three-fourths of the members of the House of Delegates present and voting may add not more than three additional bills to the 10 bill package.

Section 4. Legislation proposed by committees, sections or members of this Association that do not receive a two-thirds vote allowing it to be a part of the Legislative package to be sponsored by the Association but that does receive approving vote of 51% of those present and voting, may be reported by the Lobbyist as approved by the Association and the Legislation Committee cannot reverse that approval.

ARTICLE XI
VOTE ON RESOLUTIONS

Any Resolution that has been filed thirty days before an annual or semi-annual meeting and referred to the Resolution Committee in accordance with Article XII of the Constitution shall not be subject to a Motion to Table until:

A. The report of the Resolutions Committee has been received, and

B. The author of the Resolution has been given an opportunity to speak to the House, (Resolutions submitted by Sections, committees, etc. of the Association will designate the official spokesperson) and

C. A second to the Report of the Resolutions Committee has been received.

Procedure of the House of Delegates

As of June 2009

Rule I. Meetings of the House.

1. The Executive Council or the President of the Arkansas Bar Association shall determine the times and places of any meeting of the House. Any special meeting of the House must be held within 60 days of the call, and notice of such meeting shall include the purposes of the call. The Arkansas Bar Association is referred to as "the Association" for purposes of these Rules.

2. Notice of any meeting of the House shall be announced to the membership of the Association by mail by the Secretary at least 15 days prior to the first day of such meeting. The Secretary shall include with the notice of any meeting a calendar of the business of the meeting, if the same has been furnished to him. If such calendar is not available when the notice of the meeting is sent, the Secretary shall send the same to the members of the House as soon as it is made available.

3. Meetings of the House shall be open to attendance by members of the Association. Representatives of the news media may attend sessions of the House.

4. At all meetings of the House, members of the House may be seated by State Bar Districts and by Delegate Districts within each such Bar District. Members of the Association who are not members of the House shall be seated separately from the House members, but shall have the privileges of the floor by consent of the House, given by majority vote.

Rule II. Presiding Officer.

1. The President of the Association shall preside at meetings of the House. In his absence, the President-Elect of the Association shall preside.

2. The presiding officer shall preserve order and shall have the power to designate members of the House to aid him in so doing. He shall require observance of the Rules of the House and shall decide questions of order and procedure, subject to majority vote of the members present. On an appeal by a member from a ruling by the presiding officer, no member shall speak more than once except by unanimous consent.

3. The President shall sign every resolution and attest every report adopted by the House and the report of proceedings in the House Record, after approving its accuracy.

4. Proceedings of the House shall be governed by the Constitution and By-Laws of the Association and by the rules of this House and, where not in conflict therewith, Robert's Rules of Order.

Rule III. Certification of Delegates.

The Secretary shall certify at each annual meeting the election of members to the House of Delegates and shall maintain a roster of the membership of the House. This roster shall be open to examination by any member of the Association.

Rule IV. House Record.

1. The proceedings of the House shall be stated in its Record kept by the Secretary. After the adjournment of a meeting, the tape recorded and recorded minutes taken by the Secretary shall be kept on file in the office of the Association.

2. Each member shall report the substance of the proceedings of each House session to the respective Delegate District. If any Delegate District is represented by more than one Delegate, the majority of such Delegates may designate one of their number to make that report.

Rule V. The Order of Business.

1. The order of business of the House each day shall include the following:

(a) The presiding officer and the Secretary of the House shall verify the presence of a quorum based on a review of the attendance roster submitted to each House member at the initiation of the House session;
(b) Unfinished business from the preceding day session;
(c) The special orders of business for the day;
(d) New business.

Any subject may, by a vote of two-thirds of the members present, be made a special order.

2. The agenda for each meeting of the House shall include any matters which any Section or Standing or Special Committee of the Association wishes to bring before the House.

3. Questions relating to the priority of business shall be decided by the presiding officer, subject to appeal to the House. Any such appeals shall be decided by majority vote of the members present.

Rule VI. Quorum.

1. A quorum of the House shall consist of a majority of the voting membership of the House. The presiding officer shall determine that a quorum is present.

2. If at any time during a session of the House, any member shall question the presence of a quorum, the presiding officer shall resolve said question by a call of the roll or otherwise. If it shall thus be determined that a quorum is not present, the presiding officer may direct the Secretary to request the attendance of absent members. During the time when it has been determined that a quorum is not present, no debate or motion, except to recess or to adjourn, shall be in order.

Rule VII. Debate and Reports.

1. When a member of the House desires to speak, he shall rise and address the presiding officer. The member who made the motion under discussion shall have the right to close the debate upon it.

2. No person shall speak more than ten minutes at one time without unanimous consent of the House, unless he be then engaged in making the report of a Section of the Association or of a Committee of the Association or of the House. A Chair of a Section or Standing or Special Committee of the Association may have the privileges of the floor, without

vote, and may speak, or make a motion, only concerning any report of his or her Section or Committee or any matter within the jurisdiction of his or her Section or Committee. When a minority report has been filed in connection with a Committee or Section report, one representative of the minority, selected by the minority for that purpose, shall have the privileges of the Floor, without vote, to speak once, not to exceed ten minutes, upon the question.

3. At the request of the presiding officer or of any member, any resolution or motion shall be reduced to writing. Such a resolution or motion shall be read before it may be debated. The House or presiding officer may require that copies of any resolution shall be made available to members of the House, before a vote is taken thereon.

4. Wherever practicable, copies of each report by a Committee of the Association or of the House shall be made available to each member of the House, before or at the time of the presentation of such report. Unless otherwise ordered by the vote of the House or directed by the presiding officer, reports of Sections and Committees of the Association that are distributed in advance, or of which copies are available at the meeting, shall not be read orally in presentation. When the reading is called for and objected to, the reading shall be determined by a vote of the House, without debate.

Rule VIII. Voting.

1. Except where a roll call is ordered, voting shall be by voice, unless the presiding officer is in doubt of the result or a division is requested.

2. When a question has been decided by the House, any member with the prevailing side, may, on the same day, move for a reconsideration. If the House shall refuse to reconsider or upon reconsideration shall affirm its first decision, no further motion to reconsider shall be in order unless by unanimous consent.

Rule IX. Committee of the House.

1. The House may from time to time create and have such Committees of the House as it may deem desirable for the furtherance of its business.

2. For the purpose of furthering the consideration of a subject at any meeting of the House, the President may, in his discretion and in advance of such meeting, appoint a special Committee of not more than five members, to consider such subject and report to the House concerning it. Unless otherwise voted by the House, any Committee so appointed shall not continue beyond the adjournment of that meeting of the House.

3. Unless otherwise directed by the House as to a particular committee, the President shall appoint the Committees of the House and shall fill vacancies arising in any Committee of the House.

4. Except where otherwise provided by the House, each Committee of the House shall serve until adjournment of the next meeting of the House after appointment, and thereafter until their successors have been appointed.

Rule X. Amendment and Suspension of the Rules.

1. No motion to amend any Rule or any part thereof shall be in order, unless notice of such motion shall have been filed with the Secretary in writing, specifying the Rule or part thereof proposed to be amended and the purpose of the amendment, and unless 15 days notice of such motion shall have been given by the Secretary to each member of the House. A

vote of two-thirds of those members present at any session and not less than a majority of those who have signed the attendance roster and are actually present at the House meeting for which notice of the amendment was given, shall be required to amend the Rules.

2. By a two-thirds vote of the members voting at a session of the House, Rule V, or any part thereof, may be suspended during such session of the House, without advance notice.

AMERITAS
LIFE INSURANCE CORP.
A UNIFI Company

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL AND EYE CARE INSURANCE POLICY

The Policyholder	**ARKANSAS BAR ASSOCIATION**		
		Policy Number	**10-350682**
State of Delivery	**Arkansas**	**Plan Effective Date**	**January 1, 2011**
Premium Due Date 1st of each month.		**Renewal Date**	**January 1**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

AMERITAS LIFE INSURANCE CORP.

Jan M. Connolly
Secretary

JoAnn M Martin
President

IMPORTANT INFORMATION TO POLICYHOLDERS

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the following address and telephone number:

Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, NE 68501-1889
1-800-366-5933

Name of Agent: REGIONS INSURANCE INC
Address: PO BOX 3198 LITTLE ROCK, AR 72203-3198
Telephone Number: 501-661-4942

If you have been unable to contact or obtain satisfaction from the company or the agent, or we fail to provide you with reasonable and adequate service, you may contact the Arkansas Insurance Department at:

Consumer Services Division
Arkansas Insurance Department
1200 W. Third Street
Little Rock, AR 72201-1904
1-800-852-5494

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Department of Insurance, have your policy number available.

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a

member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

* They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
* The insurer was not authorized to do business in this state;
* Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

* Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
* Any policy of reinsurance (unless an assumption certificate was issued);
* Interest rate yields that exceed an average rate;
* Dividends and voting rights and experience rating credits;
* Credits given in connection with the administration of a policy by a group contract holder;
* Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
* Unallocated annuity contracts (which give rights to group contract holders, not individuals);
* Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
* Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
* Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
* Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
* Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third- party service providers to provide you access to discounted goods and/or services, such as purchase of eye wear or prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	Member Enrolled In Dental Plan
Class 2	Member Enrolled In Eye Care Plan

Class Number 1

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

Coinsurance Percentage:	
Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	50%

Maximum Amount - Each Benefit Period	$1,000

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on December 31, 2010, and
b. on January 1, 2011 is both:

   i. insured under the policy, and

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

Class Number 2

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Exams - Each Benefit Period	$10
Frames and Lenses - Each Benefit Period	$25

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

Class Number 1

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
PPO Bonus – Each Benefit Period	$100
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

After the first Benefit Period following the coverage effective date, the Carry Over Amount will be increased by the PPO Bonus if:

a) The insured person has submitted a claim for dental expenses incurred during the preceding benefit period, and

b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider, and

c) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount and the PPO Bonus.

The Carry Over Amount and the PPO Bonus can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount or PPO Bonus for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount or PPO Bonus for that Benefit Period, and any accumulated Carry Over Amounts, including any PPO Bonuses from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount and the PPO Bonus will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount and/or the PPO Bonus, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount or PPO Bonus calculations. The request for review must be within 24 months from the date the Carry Over Amount or the PPO Bonus was established.

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Class 1	
Dental Care Insurance	$28.08 per Insured Person
	$29.36 Spouse Only
	$38.08 Child(ren) Only
	$67.44 Spouse & Child(ren)
Orthodontic Insurance	$0.00 per Insured Person
	$0.00 Spouse Only
	$6.60 Child(ren) Only
	$6.60 Spouse & Child(ren)
Class 2	
Eye Care Insurance	$9.40 per Insured Person
	$8.72 Spouse Only
	$5.64 Child(ren) Only
	$14.36 Spouse & Child(ren)

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in

the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of one or both of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of the number of Insureds covered under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date.

Should either or both of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

Class Number 1

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 19 years of age, for whom the Insured or the Insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. newly born adopted children, eligible from birth, if the petition for adoption and the application for coverage are filed within 60 days of birth.

   iii. adopted children, eligible from the date of filing the petition for adoption if the application for coverage is filed within 60 days after the petition is filed.

   iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 19 but less than 24 who is:

   i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

   ii. primarily dependent on the Insured or the Insured's spouse for support and maintenance.

d. each unmarried child age 19 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while insured as a dependent under b. or c. above.

   We may request proof of dependency and disability of a handicapped dependent. Any costs for providing continuing proof will be at our expense. The policyholder is

responsible for furnishing such proof following our request and for notifying us when such dependency and disability has terminated.

Class Number 2

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 19 years of age, for whom the Insured or the Insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. newly born adopted children, eligible from birth, if the petition for adoption and the application for coverage are filed within 60 days of birth.

   iii. adopted children, eligible from the date of filing the petition for adoption if the application for coverage is filed within 60 days after the petition is filed.

   iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 19 but less than 24 who is:

   i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

   ii. primarily dependent on the Insured or the Insured's spouse for support and maintenance.

d. each unmarried child age 19 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while insured as a dependent under b. or c. above.

   We may request proof of dependency and disability of a handicapped dependent. Any costs for providing continuing proof will be at our expense. The policyholder is responsible for furnishing such proof following our request and for notifying us when such dependency and disability has terminated.

All Classes

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

Class Number 1

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member enrolled in dental plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member enrolled in dental plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased member continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

Class Number 2

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member enrolled in eye care plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member enrolled in eye care plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased member continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

<u>All Classes</u>

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

Class Number 1

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 2

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

All Classes

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

Class Number 1

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as determined by us, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC") as determined by us.

Usual and Customary (“U&C”) describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider’s fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

COVERAGE FOR GENERAL ANESTHESIA. Notwithstanding the limitations relating to Covered Expenses for general anesthesia (Procedure codes 9220-9242) as shown on the Table of Dental Procedures, general anesthesia administered in connection with dental procedures performed in a hospital or ambulatory surgical

facility will be considered a Covered Expense if the Provider certifies that, because of the Covered Person's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedures and the Covered Person is:

1. a child under the age of 7 who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment for a significantly complex dental condition;

2. a person with a diagnosed serious mental or physical condition; or

3. a person with a significant behavioral problem as determined by the Covered Person's physician who is licensed under the Arkansas Medical Practices Act.

All other terms and conditions of the policy will apply to these services.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

2. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

8. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

11. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

Class Number 1

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION
- D0120 Periodic oral evaluation - established patient.
- D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
- D0150 Comprehensive oral evaluation - new or established patient.
- D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180
- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145
- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC FILM
- D0210 Intraoral - complete series (including bitewings).
- D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330
- Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER XRAYS
- D0220 Intraoral - periapical first film.
- D0230 Intraoral - periapical each additional film.
- D0240 Intraoral - occlusal film.
- D0250 Extraoral - first film.
- D0260 Extraoral - each additional film.

PERIAPICAL FILMS: D0220, D0230
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

BITEWING FILMS
- D0270 Bitewing - single film.
- D0272 Bitewings - two films.
- D0273 Bitewings - three films.
- D0274 Bitewings - four films.
- D0277 Vertical bitewings - 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274
- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277
- Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

TYPE 1 PROCEDURES

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1203 Topical application of fluoride - child.
D1204 Topical application of fluoride - adult.
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 13 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

SEALANT

D1351 Sealant - per tooth.
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.

SEALANT: D1351, D1352

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 13 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.
D2150 Amalgam - two surfaces, primary or permanent.
D2160 Amalgam - three surfaces, primary or permanent.
D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.
D2331 Resin-based composite - two surfaces, anterior.
D2332 Resin-based composite - three surfaces, anterior.
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).
D2391 Resin-based composite - one surface, posterior.
D2392 Resin-based composite - two surfaces, posterior.
D2393 Resin-based composite - three surfaces, posterior.
D2394 Resin-based composite - four or more surfaces, posterior.
D2410 Gold foil - one surface.
D2420 Gold foil - two surfaces.
D2430 Gold foil - three surfaces.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.
D2930 Prefabricated stainless steel crown - primary tooth.
D2931 Prefabricated stainless steel crown - permanent tooth.
D2932 Prefabricated resin crown.
D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Recement inlay, onlay, or partial coverage restoration.
D2915 Recement cast or prefabricated post and core.
D2920 Recement crown.
D6092 Recement implant/abutment supported crown.
D6093 Recement implant/abutment supported fixed partial denture.
D6930 Recement fixed partial denture.

SEDATIVE FILLING

D2940 Protective restoration.

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510 Repair broken complete denture base.
D5520 Replace missing or broken teeth - complete denture (each tooth).
D5610 Repair resin denture base.
D5620 Repair cast framework.
D5630 Repair or replace broken clasp.
D5640 Replace broken teeth - per tooth.

DENTURE RELINES

D5730 Reline complete maxillary denture (chairside).
D5731 Reline complete mandibular denture (chairside).
D5740 Reline maxillary partial denture (chairside).
D5741 Reline mandibular partial denture (chairside).
D5750 Reline complete maxillary denture (laboratory).
D5751 Reline complete mandibular denture (laboratory).
D5760 Reline maxillary partial denture (laboratory).
D5761 Reline mandibular partial denture (laboratory).

TYPE 2 PROCEDURES

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - deciduous tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Surgical access of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Surgical reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7980 Sialolithotomy.
D7983 Closure of salivary fistula.

TYPE 2 PROCEDURES

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285 Biopsy of oral tissue - hard (bone, tooth).
D7286 Biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection.
D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
D9440 Office visit - after regularly scheduled hours.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.
D1515 Space maintainer - fixed - bilateral.
D1520 Space maintainer - removable - unilateral.
D1525 Space maintainer - removable - bilateral.
D1550 Re-cementation of space maintainer.
D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).

TYPE 3 PROCEDURES

D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic substrate.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins.
D6973 Core build up for retainer, including any pins.

CORE BUILDUP: D2950, D6973

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnotic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair, by report.
D6980 Fixed partial denture repair, by report.
D9120 Fixed partial denture sectioning.

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
D3333 Internal root repair of perforation defects.

TYPE 3 PROCEDURES

D3351 Apexification/recalcification/pulpal regeneration-initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
D3352 Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Endodontic therapy, anterior tooth.
D3320 Endodontic therapy, bicuspid tooth.
D3330 Endodontic therapy, molar.
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - bicuspid.
D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410 Apicoectomy/periradicular surgery - anterior.
D3421 Apicoectomy/periradicular surgery - bicuspid (first root).
D3425 Apicoectomy/periradicular surgery - molar (first root).
D3426 Apicoectomy/periradicular surgery (each additional root).

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - first site in quadrant.
D4264 Bone replacement graft - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4271 Free soft tissue graft procedure (including donor site surgery).
D4273 Subepithelial connective tissue graft procedures, per tooth.
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Soft tissue allograft.

TYPE 3 PROCEDURES

D4276 Combined connective tissue and double pedicle graft, per tooth.

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (maxillary).
D5821 Interim partial denture (mandibular).
D5860 Overdenture - complete, by report.
D5861 Overdenture - partial, by report.
D6053 Implant/abutment supported removable denture for completely edentulous arch.
D6054 Implant/abutment supported removable denture for partially edentulous arch.
D6078 Implant/abutment supported fixed denture for completely edentulous arch.
D6079 Implant/abutment supported fixed denture for partially edentulous arch.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

TYPE 3 PROCEDURES

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture.

DENTURE REBASES

D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

TISSUE CONDITIONING

D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
D6094 Abutment supported crown - (titanium).
D6194 Abutment supported retainer crown for FPD - (titanium).
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.

TYPE 3 PROCEDURES

D6242 Pontic - porcelain fused to noble metal.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6600 Inlay - porcelain/ceramic, two surfaces.
D6601 Inlay - porcelain/ceramic, three or more surfaces.
D6602 Inlay - cast high noble metal, two surfaces.
D6603 Inlay - cast high noble metal, three or more surfaces.
D6604 Inlay - cast predominantly base metal, two surfaces.
D6605 Inlay - cast predominantly base metal, three or more surfaces.
D6606 Inlay - cast noble metal, two surfaces.
D6607 Inlay - cast noble metal, three or more surfaces.
D6608 Onlay - porcelain/ceramic, two surfaces.
D6609 Onlay - porcelain/ceramic, three or more surfaces.
D6610 Onlay - cast high noble metal, two surfaces.
D6611 Onlay - cast high noble metal, three or more surfaces.
D6612 Onlay - cast predominantly base metal, two surfaces.
D6613 Onlay - cast predominantly base metal, three or more surfaces.
D6614 Onlay - cast noble metal, two surfaces.
D6615 Onlay - cast noble metal, three or more surfaces.
D6624 Inlay - titanium.
D6634 Onlay - titanium.
D6710 Crown - indirect resin based composite.
D6720 Crown - resin with high noble metal.
D6721 Crown - resin with predominantly base metal.
D6722 Crown - resin with noble metal.
D6740 Crown - porcelain/ceramic.
D6750 Crown - porcelain fused to high noble metal.
D6751 Crown - porcelain fused to predominantly base metal.
D6752 Crown - porcelain fused to noble metal.
D6780 Crown - 3/4 cast high noble metal.
D6781 Crown - 3/4 cast predominantly base metal.
D6782 Crown - 3/4 cast noble metal.
D6783 Crown - 3/4 porcelain/ceramic.
D6790 Crown - full cast high noble metal.
D6791 Crown - full cast predominantly base metal.
D6792 Crown - full cast noble metal.
D6794 Crown - titanium.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

TYPE 3 PROCEDURES

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

TYPE 3 PROCEDURES

CAST POST AND CORE FOR PARTIALS

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated.
D6972 Prefabricated post and core in addition to fixed partial denture retainer.

SURGICAL EXTRACTIONS

D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth - completely bony.
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Surgical removal of residual tooth roots (cutting procedure).
D7251 Coronectomy-intentional partial tooth removal.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

ANESTHESIA-GENERAL/IV

D9220 Deep sedation/general anesthesia - first 30 minutes.
D9221 Deep sedation/general anesthesia - each additional 15 minutes.
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

ORTHODONTIC EXPENSE BENEFITS

Class Number 1

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. However, the first payment will be 25 percent of the total allowed Covered Expense. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun on or after the Insured's 19 birthday.

2. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on December 31, 2010 and are both:

   a. insured under this policy; and
   b. currently undergoing a Treatment Program on January 1, 2011.

3. before the Insured has been insured under this section for at least 12 consecutive months unless the Insured is covered on January 1, 2011.

4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

5. if the Insured's insurance under this section terminates.

6. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

9. because of war or any act of war, declared or not.

10. To replace lost or stolen appliances.

EYE CARE EXPENSE BENEFITS

Class Number 2

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider.

AMOUNT PAYABLE
The Amount Payable for Covered Expenses is the lesser of:

A. the provider's charge, or

B. the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services for Participating and Non-Participating Providers.

DEDUCTIBLE AMOUNT
The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS
A Participating Provider agrees to provide services and supplies to the Insured at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES
Covered expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

EYE CARE SUPPLIES
Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES
When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits are limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS
We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless otherwise required by state regulation.

EXTENSION OF BENEFITS
We will extend benefits for eye care supplies if this policy terminates. To be eligible for an extension, the supply must be prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS
This plan has the following limitations.

1) This plan does not cover more than one Eye Exam in any 12-month period.

2) This plan does not cover more than one pair of Lenses in any 12-month period.

3) This plan does not cover more than one set of Frames in any 24-month period.

4) This plan does not cover Elective Contact Lenses more than once in any 12-month period. Contact Lenses and associated expenses are in lieu of any other Lenses or Frame benefit.

5) This plan does not cover Medically Necessary Contact Lenses more than once in any 12-month period. The treating provider determines if an Insured meets the coverage criteria for this benefit. This benefit is in lieu of Elective Contact Lenses.

6) This plan does not cover any procedure to change the shape of the cornea in order to reduce Myopia.

7) This plan does not cover the refitting of Contact Lenses after the initial 90-day fitting period.

8) This plan does not cover Plano Contact Lenses to change eye color.

9) This plan does not cover artistically painted Contact Lenses.

10) This plan does not cover contact lens insurance policies or service contracts.

11) This plan does not cover additional office visits associated with contact lens pathology.

12) This plan does not cover contact lens modification, polishing or cleaning.

13) This plan does not cover Orthoptics or vision training and any associated testing.

14) This plan does not cover Plano Lenses.

15) This plan does not cover two pairs of glasses in lieu of Bifocals.

16) This plan does not cover replacement of Lenses and Frames that are lost or broken outside of the normal coverage intervals.

17) This plan does not cover medical or surgical treatment of the eyes.

18) This plan does not cover services for claims filed more than 180 days after completion of the service. An exception is if the Insured shows it was not possible to submit the proof of loss within this period.

19) This plan does not cover the following materials over and above the Covered Expense for the basic material: blended lenses, oversized lenses, and photochromic or tinted lenses except pink #1 and #2.

20) This plan does not cover the coating or laminating of the lens or lenses.

21) This plan does not cover corrective vision treatments that are experimental.

22) This plan does not cover Corneal Refractive Therapy (CRT).

23) This plan does not cover costs for services and/or materials that exceed the Maximum Covered

Expense.

24) This plan does not cover services or materials that are cosmetic.

25) This plan does not cover any procedure not listed on the Schedule of Eye Care Services.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	***PLAN MAXIMUM COVERED EXPENSE***	
	Participating Provider	*Non-Participating Provider*
Eye Exam	Covered in Full	Up to $ 52.00
(All lenses are per pair)		
Single Vision Lenses	Covered in Full	Up to $ 55.00
Lined Bifocal Lenses	Covered in Full	Up to $ 75.00
Lined Trifocal Lenses	Covered in Full	Up to $ 95.00
Lenticular Lenses	Covered in Full	Up to $125.00
Frame	Up to $120.00	Up to $ 45.00
Contact Lenses*		
Elective	Up to $120.00	Up to $105.00
Medically Necessary	Covered in Full	Up to $210.00

An Insured can receive professional services for treatment of severe visual problems. A treating provider may prescribe Low Vision treatment. This treatment is for problems that are not correctable with regular lenses. The treating provider determines if the Insured meets the criterion for coverage of this benefit.

*The contact lenses allowance applies to the contact lens exam and lenses.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental and Eye Care coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's Dental and Eye Care expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of one and one-half percent per month on benefits for valid claims not paid within 30 days until the claim is settled. If we do not pay benefits when due, the Insured may bring legal action to recover benefits, interest and any other damages allowable by law.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured unless otherwise agreed upon through your authorization or provider contracts.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

GENERAL PROVISIONS (CONTINUED)

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to avoid the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	60%
Number of Members-	1,063

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

Arkansas Bar Association

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Media Kit

(below are links)

About the Arkansas Bar Association

Press Releases

Advertising Information

The Arkansas Lawyer Magazine

E-Bulletins

Publications Director email

Arkansas Bar Association

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About the Arkansas Bar Association

(words in bold are links & pages that follow are some of the links)

The Arkansas Bar Association, established in 1898, is a voluntary bar association with 5,000 attorney members. For over a century, the Association has been enhancing the lives of Arkansas citizens, the operation of the state's judicial system, reform of state laws, and the professionalism of lawyers.

The activities of the Arkansas Bar Association are accomplished through its volunteer members, which are organized among **committees** and **sections** and supported by a **staff** of ten. The Association's office is located in the **Arkansas Bar Center** on the banks of the Arkansas River at 2224 Cottondale Lane in Little Rock.

The officers of the Association include a **President**, **President-Elect**, **Secretary**, **Treasurer,** and **Chair of the Board of Governors**. Each officer's one-year term begins at the conclusion of the Association's **Annual Meeting**. The Association is governed by a **House of Delegates** and **Board of Governors** *(idea for HOD & BOG page-- have links for meeting reports)*. The **Young Lawyers Section** consists of all members of the Association under the age of 36 or who have been admitted to the practice of law five years or less.

The Arkansas Bar Association has sponsored new statutory laws and progressive constitutional amendments, and has increased support for the Arkansas judiciary. As far back as 1910, the Association had committees on law and law reform, as well as uniform state laws. Frequently, the Association has initiated law reform measures or has been the catalyst to secure their passage in partnership with other advocates for improved laws. The Association works closely with leaders in the judiciary and the Arkansas General Assembly to improve Arkansas's legal system.

Since the 1970s, the Arkansas Bar Association has emphasized the improvement of access to the legal system for low-income and elderly Arkansans. The Association has fought to secure and maintain federal funding for legal services for the poor and has encouraged all attorneys to participate in **pro bono programs** through which volunteer representation is provided. Additionally, the Association played the leading role in establishment of the **Arkansas Interest on Lawyers Trust Accounts (IOLTA) Foundation** by the Arkansas Supreme Court in the 1980s. The foundation administers the IOLTA program, which provides another source of funding for legal services.

Continuing legal education (CLE) is important for all attorneys, and the Arkansas Bar Association and its volunteers produce over twenty-five CLE seminars each year. Additionally, **practice handbooks** on different areas of the law are produced by association members with expertise in the specific areas. Beginning in 2007, the association sponsors a new and comprehensive **law-related education program** with initial emphasis on high school-age children. In addition, the **High School Mock Trial** project offers students throughout Arkansas an unparalleled opportunity to learn about our country's judicial system with a hands-on learning experience as they work with lawyers, judges and others in the legal system.

*Information provided from Don Hollingsworth's report on the Association for the Encyclopedia of Arkansas
http://www.encyclopediaofarkansas.net/encyclopedia/entry-detail.aspx?entryID=4555

Arkansas Bar Association

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2009-2010 Arkansas Bar Association President Donna C. Pettus

Bio

Donna Pettus of Fayetteville was sworn in as the 112th president of the Association at the Association's Annual Meeting on June 12th. Ms. Pettus was recently honored with the **Gayle Pettus Pontz Award** by the University of Arkansas School of Law Women's Law Student Assocation. The award is given to an outstanding woman attorney who has made a positive difference for her community and state. Ms. Pettus is a longtime active member of the Association. She was honored with a Golden Gavel award in 2006 for her work as chair of the Judicial Nominations Committee, a committee she chaired for several years. She was instrumental in planning the design and interior decorating of the new Bar Center, while serving as the chair of the Interior Design Subcommittee. She is a former Governor of the Board of Governors and a former member of the House of Delegates. She has served as chair of the Disability Law Committee and served on the Legislation Committee. She is a Sustaining Fellow of the Arkansas Bar Foundation and the Association. She has twice served as a special justice to the Arkansas Supreme Court. She has served one term on the Fayetteville City Council. She earned an undergraduate degree in English and Journalism from the University of Arkansas and a Juris Doctorate from the University of Arkansas School of Law at Fayetteville. Ms. Pettus is married to Past President Lamar Pettus and they are the first lawyer couple in Arkansas to both serve as President of the Association.

Links

Feature article in the 2009 Summer issue of The Arkansas Lawyer magazine

Press Release on Gayle Pettus Ponce Award

Link to Donna's blog

(This page could be archived under a Past Presidents link when term expired)

Arkansas Bar Association

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2009-2010 Arkansas Bar Association President-Elect Jim L. Julian

Bio

Jim Julian of Little Rock assumed the office of President-Elect at the Annual Meeting. Mr. Julian is a partner with Chisenhall, Nestrud & Julian, P.A. in Little Rock. He is a former Governor of the Board of Governors and former member of the House of Delegates. He has chaired numerous committees and task forces for the Association, including the successful effort to amend the Judicial Article of the Arkansas Constitution in November 2000. He was honored with the Presidential Award at this year's Annual Meeting for his work as chair of the Ark Bar PAC. He is past chair of the Long Range Planning Committee, Legislative Task Force, Annual Meeting Committee and Legislation Committee. He is a recipient of the Charles C. Carpenter Award, the Outstanding Lawyer-Citizen Award and has received two Golden Gavel awards. Mr. Julian serves on the Board of Directors of the Boys and Girls Clubs of Central Arkansas and is a former chairman of that Board. He is the chair of the Board of Directors for Recovery Centers of Arkansas. He serves on the North Little Rock Airport Commission and the finance committee and as counsel for Lakewood United Methodist Church. He received a bachelor's degree from Arkansas State University and a Juris Doctorate from the University of Arkansas School of Law in Fayetteville.

Arkansas Bar Association

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2009-2010 Arkansas Bar Association Board of Governors Chair Frank B. Sewall

Bio

Frank B. Sewall of Little Rock has been appointed by President Donna Pettus to chair the Association's Board of Governors. Mr. Sewall is Senior Counsel, Regulatory for Arkansas Blue Cross and Blue Shield. He served as Secretary/Treasurer of the Association from June 1994 through June 1996. He is a tenured member of the House of Delegates. He was honored with the Golden Gavel Award at this year's Annual Meeting for his work as chair of the Organization and Redistricting Committee. He received a Golden Gavel Award in 1995 for his work as co-chair of the Joint Planning Group for the Future Bar Center. He is a recipient of the Presidential Award and Charles C. Carpenter Award. He has served as chair of the House Committee, Planning/Design Committee, and Finance Committee. A Fellow of the Arkansas Bar Foundation, he currently serves as its Vice President and served as its Secretary/Treasurer this past year. He was a commissioned Officer in the U.S. Navy Supply Corps. Mr. Sewall is a member of the Pulaski County Bar Association, where he served as President in 1988. Mr. Sewall is a member of the Saint Thomas More Society of Arkansas, serving as President in 2003. He is a member of the Board of Directors of IOLTA. Mr. Sewall graduated from Dartmouth College with an MBA. He obtained a Juris Doctorate from Emory University School of Law.

Arkansas Bar Association

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2009-2010 Arkansas Bar Association Treasurer William A. Martin

Bio

William A. Martin has again been elected to serve as Treasurer. Col. Martin served as executive director of the Association for 13 years and has served as its Secretary/Treasurer for the past nine years. Martin has been a member of the Association's House of Delegates for a number of years and has served as chair of the Finance Committee since 2000. He is a Sustaining Member of the Association and the Arkansas Bar Foundation, a member of the Board of Directors of the Pulaski County Bar Association, treasurer and past secretary of the Pulaski County Bar Foundation, and served seven years as a Board of Trustees member of the National Conference of Bar Foundations including four as its treasurer. Martin received a Juris Doctorate from the University of Arkansas before entering the United States Air Force where he moved through the ranks from second lieutenant to colonel. During that time he also earned an MBA from Arizona State University.

Arkansas Bar Association

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2009-2010 Arkansas Bar Association Parliamentarian Charles D. Roscopf

Bio

Charles D. Roscopf was elected the new Parliamentarian of the Association. Mr. Roscopf is a partner at Roscopf & Roscopf in Helena. He is a former Governor of the Board of Governors and member of the House of Delegates. He is a Fellow of the Arkansas Bar Foundation and has served on its Trust Committee and the Board of Directors. He is a member of the Arkansas Alumni Association Board. He is the managing partner of East Arkansas Title Co., LLC in Helena. He is a member of the Phillips County Bar Association and Arkansas Supreme Court Continuing Legal Education Committee, where he served as chairman. He is a member of Arkansas Volunteer Lawyers for the Elderly. Mr. Roscopf is a graduate of the Phillips County Chamber of Commerce Leadership Development Institute. He received a bachelor's degree from the University of Arkansas and a Juris Doctorate from the University of Arkansas School of Law in Fayetteville.

Arkansas Bar Association

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2009-2010 Arkansas Bar Association Young Lawyers Section Chair Anthony W. Juneau

Bio

Anthony W. Juneau of Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C. in Rogers has been named chair of the Young Lawyers Section. He currently serves on the Bar Leaders Handbook and Benefits Task Force, Executive Committee and Long Range Planning Committee of the Arkansas Bar Association. He graduated Cum Laude from the University of Arkansas at Fayetteville in 2001 with a B.S.B.A. (Finance) and earned a Juris Doctorate with high honors from the University of Arkansas at Little Rock William H. Bowen School of Law in 2004, where he served as Managing Editor of the UALR Law Review. He is a member of the American Bar Association, Benton County Bar Association, Sigma Alpha Epsilon Fraternity and the National Eagle Scout Association.

Links

YLS Page

Arkansas Bar Association

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2010-2011 Membership Form
July 1, 2010 through June 30, 2011

Annual Dues Payable by July 1

Name _____ Supreme Court # _____

❒ Check box if contact information is correct. Review your information in the Online Member Directory at www.arkbar.com.

Mailing Address _____

City_____ State _____ Zip + 4 _____ - _____

Phone # (_____)_____ Fax # (_____)_____ Birth Year _____

E-Mail Address (please print) _____

Select One Dues Category for Payment

Membership Dues:	*Select One*
Standard or Associate	❒ **$210**
(**OR** select **one** income range option)	
$0-$25,000	❒ **$55**
$25,001-$50,000	❒ **$100**
$50,001-$75,000	❒ **$145**
$75,001-$125,000	❒ **$210**
over $125,000	❒ **$275**
First Full Year Admitted to Practice	❒ **$45**
Out-of-State Residents	❒ **$70**
Senior Membership	❒ **$0**
Law Student Membership	❒ **$0**
Sustaining Member	❒ **$100**
Total Section Dues	❒ **$** ____
Ark Bar PAC (minimum $30)	❒ **$** ____

Total amount enclosed **$** ____

Check if you want to be an annual event sponsor ❒

Membership Dues Categories

Standard Dues
are $210 except that one may elect to use the income scale to determine the amount of dues. "Income" for this purpose is law-related salary, wages or income after deducting office overhead and other necessary business expenses but before taxes, FICA, insurance and pension contributions, for the current or immediately preceding year.

Associate Members
are attorneys who are only licensed in a state(s) other than Arkansas and are residents of Arkansas or are a full time employee of a business organization which regularly does business within Arkansas. Associate members choose standard or use income range option.

First Full Year Admitted
applies to attorneys' first full bar year (July - June) following their admission to practice.

Out-of-State Dues
are for non-residents of Arkansas who have no regular law practice in Arkansas.

Senior Members
are attorneys who are 75 years of age or older and who have been a member for 10 continuous years.

Law Students
are students currently enrolled at an accredited law school in Arkansas.

Sustaining Members *are members who pay $100/year in addition to dues to support Association programs.*

Federal Law makes part of your membership dues used for lobbying non-deductible as a business expense. 9.25% of dues is non-deductible.

Method of Payment

❒ Check ❒ Visa/MC ❒ AMEX

Pay online at www.arkbar.com

Card#: _____

Exp. date: _____

Signature: _____

Make check payable to:
Arkansas Bar Association,
2224 Cottondale Lane, LR, AR 72202
or FAX : (501) 375-4901
Questions? Contact Crystal Newton at
800.609.5668, 501.375.4606
or cnewton@arkbar.com

Check the Section(s) You Wish to Join

❒ Administrative Law	$10	❒ Intellectual Property	$10
❒ Agricultural Law	$15	❒ Int'l & Immigration	$10
❒ ADR	$20	❒ Juvenile Justice & Child Welfare	$10
❒ Business Law	$10	❒ Labor & Employment	$10
❒ Civil Litigation	$10	❒ Natural Resources	$20
❒ Construction Law	$20	❒ Probate & Trust	$10
❒ Corporate & In-House Counsel	$20	❒ Real Estate Law	$20
❒ Criminal Law	$20	❒ Securities	$10
❒ Debtor/Creditor	$20	❒ Solo, Small Firm & Practice Mgmt.	$10
❒ Disability Law	$10	❒ Tax Law	$20
❒ Elder Law	$20	❒ Tort Law	$10
❒ Environmental Law	$35	❒ Workers' Comp.	$10
❒ Family Law	$10	❒ Young Lawyers	*free*
❒ Financial Institutions	$15	*(automatic member if you qualify)*	
❒ Government Practice	$10		
❒ Health Law	$10		

Law Students may join sections by contacting cnewton@arkbar.com

Total Section(s) $_____ (Add to total payment above)

AMERITAS
LIFE INSURANCE CORP.
A UNIFI Company

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE
GROUP DENTAL INSURANCE

The Policyholder **ARKANSAS BAR ASSOCIATION**

Policy Number **10-350682** **Insured Person**

Plan Effective Date **January 1, 2011** **Certificate Effective Date**
Refer to Exceptions on 9070.

Class Number 1

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

JoAnn M Martin

President

IMPORTANT INFORMATION TO POLICYHOLDERS

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the following address and telephone number:

Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, NE 68501-1889
1-800-366-5933

Name of Agent: REGIONS INSURANCE INC
Address: PO BOX 3198 LITTLE ROCK, AR 72203-3198
Telephone Number: 501-661-4942

If you have been unable to contact or obtain satisfaction from the company or the agent, or we fail to provide you with reasonable and adequate service, you may contact the Arkansas Insurance Department at:

Consumer Services Division
Arkansas Insurance Department
1200 W. Third Street
Little Rock, AR 72201-1904
1-800-852-5494

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Department of Insurance, have your policy number available.

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third- party service providers to provide you access to discounted goods and/or services, such as purchase of prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

Dental procedures not covered under your plan may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	Member Enrolled In Dental Plan

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$50

Coinsurance Percentage:

Type 1 Procedures	100%
Type 2 Procedures	80%
Type 3 Procedures	50%

Maximum Amount - Each Benefit Period	$1,000

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on December 31, 2010, and
b. on January 1, 2011 is both:

   i. insured under the policy, and

   ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Orthodontic Procedures. Please refer to the ORTHODONTIC EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
PPO Bonus – Each Benefit Period	$100
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

After the first Benefit Period following the coverage effective date, the Carry Over Amount will be increased by the PPO Bonus if:

a) The insured person has submitted a claim for dental expenses incurred during the preceding benefit period, and

b) At least one of the claims submitted by the insured person for dental expenses incurred during the preceding benefit period were expenses resulting from services rendered by a Participating Provider, and

c) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount and the PPO Bonus.

The Carry Over Amount and the PPO Bonus can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount or PPO Bonus for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount or PPO Bonus for that Benefit Period, and any accumulated Carry Over Amounts, including any PPO Bonuses from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount and the PPO Bonus will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount and/or the PPO Bonus, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount or PPO Bonus calculations. The request for review must be within 24 months from the date the Carry Over Amount or the PPO Bonus was established.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 19 years of age, for whom the Insured or the Insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. newly born adopted children, eligible from birth, if the petition for adoption and the application for coverage are filed within 60 days of birth.

   iii. adopted children, eligible from the date of filing the petition for adoption if the application for coverage is filed within 60 days after the petition is filed.

   iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 19 but less than 24 who is:

   i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

   ii. primarily dependent on the Insured or the Insured's spouse for support and maintenance.

d. each unmarried child age 19 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while insured as a dependent under b. or c. above.

   We may request proof of dependency and disability of a handicapped dependent. Any costs for providing continuing proof will be at our expense. The policyholder is responsible for furnishing such proof following our request and for notifying us when such dependency and disability has terminated.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member enrolled in dental plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member enrolled in dental plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased member continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured’s dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance

premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as determined by us, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC") as determined by us.

Usual and Customary (“U&C”) describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider’s fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

COVERAGE FOR GENERAL ANESTHESIA. Notwithstanding the limitations relating to Covered Expenses for general anesthesia (Procedure codes 9220-9242) as shown on the Table of Dental Procedures, general anesthesia administered in connection with dental procedures performed in a hospital or ambulatory surgical facility will be considered a Covered Expense if the Provider certifies that, because of the Covered Person's age,

condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedures and the Covered Person is:

1. a child under the age of 7 who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment for a significantly complex dental condition;

2. a person with a diagnosed serious mental or physical condition; or

3. a person with a significant behavioral problem as determined by the Covered Person's physician who is licensed under the Arkansas Medical Practices Act.

All other terms and conditions of the policy will apply to these services.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

2. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

3. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

8. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

11. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
D0150 Comprehensive oral evaluation - new or established patient.
D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 1 of any of these procedures per 6 month(s).
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC FILM

D0210 Intraoral - complete series (including bitewings).
D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER XRAYS

D0220 Intraoral - periapical first film.
D0230 Intraoral - periapical each additional film.
D0240 Intraoral - occlusal film.
D0250 Extraoral - first film.
D0260 Extraoral - each additional film.

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

BITEWING FILMS

D0270 Bitewing - single film.
D0272 Bitewings - two films.
D0273 Bitewings - three films.
D0274 Bitewings - four films.
D0277 Vertical bitewings - 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Vertical bitewings are considered at an alternate benefit of a D0274 and count towards this frequency. The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1203 Topical application of fluoride - child.

TYPE 1 PROCEDURES

D1204 Topical application of fluoride - adult.
D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Benefits are considered for persons age 13 and under.
- An adult fluoride is considered for individuals age 14 and over when eligible. A child fluoride is considered for individuals age 13 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

SEALANT

D1351 Sealant - per tooth.
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.

SEALANT: D1351, D1352

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 13 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.
D2150 Amalgam - two surfaces, primary or permanent.
D2160 Amalgam - three surfaces, primary or permanent.
D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.
D2331 Resin-based composite - two surfaces, anterior.
D2332 Resin-based composite - three surfaces, anterior.
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).
D2391 Resin-based composite - one surface, posterior.
D2392 Resin-based composite - two surfaces, posterior.
D2393 Resin-based composite - three surfaces, posterior.
D2394 Resin-based composite - four or more surfaces, posterior.
D2410 Gold foil - one surface.
D2420 Gold foil - two surfaces.
D2430 Gold foil - three surfaces.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

TYPE 2 PROCEDURES

- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.
D2930 Prefabricated stainless steel crown - primary tooth.
D2931 Prefabricated stainless steel crown - permanent tooth.
D2932 Prefabricated resin crown.
D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Recement inlay, onlay, or partial coverage restoration.
D2915 Recement cast or prefabricated post and core.
D2920 Recement crown.
D6092 Recement implant/abutment supported crown.
D6093 Recement implant/abutment supported fixed partial denture.
D6930 Recement fixed partial denture.

SEDATIVE FILLING

D2940 Protective restoration.

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D1110, D1120, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR

D5510 Repair broken complete denture base.
D5520 Replace missing or broken teeth - complete denture (each tooth).
D5610 Repair resin denture base.
D5620 Repair cast framework.
D5630 Repair or replace broken clasp.
D5640 Replace broken teeth - per tooth.

DENTURE RELINES

D5730 Reline complete maxillary denture (chairside).
D5731 Reline complete mandibular denture (chairside).
D5740 Reline maxillary partial denture (chairside).
D5741 Reline mandibular partial denture (chairside).
D5750 Reline complete maxillary denture (laboratory).
D5751 Reline complete mandibular denture (laboratory).
D5760 Reline maxillary partial denture (laboratory).
D5761 Reline mandibular partial denture (laboratory).

TYPE 2 PROCEDURES

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - deciduous tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Surgical access of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Surgical reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7980 Sialolithotomy.
D7983 Closure of salivary fistula.

TYPE 2 PROCEDURES

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285 Biopsy of oral tissue - hard (bone, tooth).
D7286 Biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection.
D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
D9440 Office visit - after regularly scheduled hours.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.
D1515 Space maintainer - fixed - bilateral.
D1520 Space maintainer - removable - unilateral.
D1525 Space maintainer - removable - bilateral.
D1550 Re-cementation of space maintainer.
D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).

TYPE 3 PROCEDURES

D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic substrate.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.
D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins.
D6973 Core build up for retainer, including any pins.

CORE BUILDUP: D2950, D6973

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnotic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair, by report.
D6980 Fixed partial denture repair, by report.
D9120 Fixed partial denture sectioning.

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
D3333 Internal root repair of perforation defects.

TYPE 3 PROCEDURES

D3351 Apexification/recalcification/pulpal regeneration-initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
D3352 Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Endodontic therapy, anterior tooth.
D3320 Endodontic therapy, bicuspid tooth.
D3330 Endodontic therapy, molar.
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - bicuspid.
D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410 Apicoectomy/periradicular surgery - anterior.
D3421 Apicoectomy/periradicular surgery - bicuspid (first root).
D3425 Apicoectomy/periradicular surgery - molar (first root).
D3426 Apicoectomy/periradicular surgery (each additional root).

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - first site in quadrant.
D4264 Bone replacement graft - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4271 Free soft tissue graft procedure (including donor site surgery).
D4273 Subepithelial connective tissue graft procedures, per tooth.
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Soft tissue allograft.

TYPE 3 PROCEDURES

D4276 Combined connective tissue and double pedicle graft, per tooth.

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth).
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth).
D5281 Removable unilateral partial denture - one piece cast metal (including clasps and teeth).
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (maxillary).
D5821 Interim partial denture (mandibular).
D5860 Overdenture - complete, by report.
D5861 Overdenture - partial, by report.
D6053 Implant/abutment supported removable denture for completely edentulous arch.
D6054 Implant/abutment supported removable denture for partially edentulous arch.
D6078 Implant/abutment supported fixed denture for completely edentulous arch.
D6079 Implant/abutment supported fixed denture for partially edentulous arch.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

TYPE 3 PROCEDURES

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture.

DENTURE REBASES

D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

TISSUE CONDITIONING

D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

PROSTHODONTICS - FIXED

D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal).
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).
D6094 Abutment supported crown - (titanium).
D6194 Abutment supported retainer crown for FPD - (titanium).
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.

TYPE 3 PROCEDURES

D6242 Pontic - porcelain fused to noble metal.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6600 Inlay - porcelain/ceramic, two surfaces.
D6601 Inlay - porcelain/ceramic, three or more surfaces.
D6602 Inlay - cast high noble metal, two surfaces.
D6603 Inlay - cast high noble metal, three or more surfaces.
D6604 Inlay - cast predominantly base metal, two surfaces.
D6605 Inlay - cast predominantly base metal, three or more surfaces.
D6606 Inlay - cast noble metal, two surfaces.
D6607 Inlay - cast noble metal, three or more surfaces.
D6608 Onlay - porcelain/ceramic, two surfaces.
D6609 Onlay - porcelain/ceramic, three or more surfaces.
D6610 Onlay - cast high noble metal, two surfaces.
D6611 Onlay - cast high noble metal, three or more surfaces.
D6612 Onlay - cast predominantly base metal, two surfaces.
D6613 Onlay - cast predominantly base metal, three or more surfaces.
D6614 Onlay - cast noble metal, two surfaces.
D6615 Onlay - cast noble metal, three or more surfaces.
D6624 Inlay - titanium.
D6634 Onlay - titanium.
D6710 Crown - indirect resin based composite.
D6720 Crown - resin with high noble metal.
D6721 Crown - resin with predominantly base metal.
D6722 Crown - resin with noble metal.
D6740 Crown - porcelain/ceramic.
D6750 Crown - porcelain fused to high noble metal.
D6751 Crown - porcelain fused to predominantly base metal.
D6752 Crown - porcelain fused to noble metal.
D6780 Crown - 3/4 cast high noble metal.
D6781 Crown - 3/4 cast predominantly base metal.
D6782 Crown - 3/4 cast noble metal.
D6783 Crown - 3/4 porcelain/ceramic.
D6790 Crown - full cast high noble metal.
D6791 Crown - full cast predominantly base metal.
D6792 Crown - full cast noble metal.
D6794 Crown - titanium.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

TYPE 3 PROCEDURES

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 10 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

TYPE 3 PROCEDURES

CAST POST AND CORE FOR PARTIALS

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated.
D6972 Prefabricated post and core in addition to fixed partial denture retainer.

SURGICAL EXTRACTIONS

D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth - completely bony.
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Surgical removal of residual tooth roots (cutting procedure).
D7251 Coronectomy-intentional partial tooth removal.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

ANESTHESIA-GENERAL/IV

D9220 Deep sedation/general anesthesia - first 30 minutes.
D9221 Deep sedation/general anesthesia - each additional 15 minutes.
D9241 Intravenous conscious sedation/analgesia - first 30 minutes.
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes.

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

ORTHODONTIC EXPENSE BENEFITS

We will determine orthodontic expense benefits according to the terms of the group policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations.

Usual and Customary (“U&C”) describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by your provider and is not indicative of the appropriateness of the provider’s fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the active appliances are inserted. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. However, the first payment will be 25 percent of the total allowed Covered Expense. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun on or after the Insured's 19 birthday.

2. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on December 31, 2010 and are both:

   a. insured under this policy; and
   b. currently undergoing a Treatment Program on January 1, 2011.

3. before the Insured has been insured under this section for at least 12 consecutive months unless the Insured is covered on January 1, 2011.

4. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

5. if the Insured's insurance under this section terminates.

6. for which the Insured is entitled to benefits under any workmen’s compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

7. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

8. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

9. because of war or any act of war, declared or not.

10. To replace lost or stolen appliances.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's Dental expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of one and one-half percent per month on benefits for valid claims not paid within 30 days until the claim is settled. If we do not pay benefits when due, the Insured may bring legal action to recover benefits, interest and any other damages allowable by law.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured unless otherwise agreed upon through your authorization or provider contracts.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

AMERITAS
LIFE INSURANCE CORP.
A UNIFI Company

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE
GROUP EYE CARE INSURANCE

The Policyholder **ARKANSAS BAR ASSOCIATION**

Policy Number **10-350682** **Insured Person**

Plan Effective Date **January 1, 2011** **Certificate Effective Date**
Refer to Exceptions on 9070.

Class Number 2

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

JoAnn M Martin

President

IMPORTANT INFORMATION TO POLICYHOLDERS

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the following address and telephone number:

Ameritas Life Insurance Corp.
P.O. Box 81889
Lincoln, NE 68501-1889
1-800-366-5933

Name of Agent: REGIONS INSURANCE INC
Address: PO BOX 3198 LITTLE ROCK, AR 72203-3198
Telephone Number: 501-661-4942

If you have been unable to contact or obtain satisfaction from the company or the agent, or we fail to provide you with reasonable and adequate service, you may contact the Arkansas Insurance Department at:

Consumer Services Division
Arkansas Insurance Department
1200 W. Third Street
Little Rock, AR 72201-1904
1-800-852-5494

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Department of Insurance, have your policy number available.

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third- party service providers to provide you access to discounted goods and/or services, such as purchase of eye wear or prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 2	Member Enrolled In Eye Care Plan

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Exams - Each Benefit Period	$10
Frames and Lenses - Each Benefit Period	$25

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 19 years of age, for whom the Insured or the Insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. newly born adopted children, eligible from birth, if the petition for adoption and the application for coverage are filed within 60 days of birth.

   iii. adopted children, eligible from the date of filing the petition for adoption if the application for coverage is filed within 60 days after the petition is filed.

   iv. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 19 but less than 24 who is:

   i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

   ii. primarily dependent on the Insured or the Insured's spouse for support and maintenance.

d. each unmarried child age 19 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while insured as a dependent under b. or c. above.

   We may request proof of dependency and disability of a handicapped dependent. Any costs for providing continuing proof will be at our expense. The policyholder is responsible for furnishing such proof following our request and for notifying us when such dependency and disability has terminated.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any member enrolled in eye care plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any member enrolled in eye care plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased member continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

OPEN ENROLLMENT. If a Member does not elect to participate when initially eligible, the Member may elect to participate at the Policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured’s dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider.

AMOUNT PAYABLE
The Amount Payable for Covered Expenses is the lesser of:

A. the provider's charge, or

B. the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services for Participating and Non-Participating Providers.

DEDUCTIBLE AMOUNT
The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS
A Participating Provider agrees to provide services and supplies to the Insured at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES
Covered expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

EYE CARE SUPPLIES
Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES
When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits are limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS
We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless otherwise required by state regulation.

EXTENSION OF BENEFITS
We will extend benefits for eye care supplies if this policy terminates. To be eligible for an extension, the supply must be prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS
This plan has the following limitations.

1) This plan does not cover more than one Eye Exam in any 12-month period.

2) This plan does not cover more than one pair of Lenses in any 12-month period.

3) This plan does not cover more than one set of Frames in any 24-month period.

4) This plan does not cover Elective Contact Lenses more than once in any 12-month period. Contact Lenses and associated expenses are in lieu of any other Lenses or Frame benefit.

5) This plan does not cover Medically Necessary Contact Lenses more than once in any 12-month period. The treating provider determines if an Insured meets the coverage criteria for this benefit. This benefit is in lieu of Elective Contact Lenses.

6) This plan does not cover any procedure to change the shape of the cornea in order to reduce Myopia.

7) This plan does not cover the refitting of Contact Lenses after the initial 90-day fitting period.

8) This plan does not cover Plano Contact Lenses to change eye color.

9) This plan does not cover artistically painted Contact Lenses.

10) This plan does not cover contact lens insurance policies or service contracts.

11) This plan does not cover additional office visits associated with contact lens pathology.

12) This plan does not cover contact lens modification, polishing or cleaning.

13) This plan does not cover Orthoptics or vision training and any associated testing.

14) This plan does not cover Plano Lenses.

15) This plan does not cover two pairs of glasses in lieu of Bifocals.

16) This plan does not cover replacement of Lenses and Frames that are lost or broken outside of the normal coverage intervals.

17) This plan does not cover medical or surgical treatment of the eyes.

18) This plan does not cover services for claims filed more than 180 days after completion of the service. An exception is if the Insured shows it was not possible to submit the proof of loss within this period.

19) This plan does not cover the following materials over and above the Covered Expense for the basic material: blended lenses, oversized lenses, and photochromic or tinted lenses except pink #1 and #2.

20) This plan does not cover the coating or laminating of the lens or lenses.

21) This plan does not cover corrective vision treatments that are experimental.

22) This plan does not cover Corneal Refractive Therapy (CRT).

23) This plan does not cover costs for services and/or materials that exceed the Maximum Covered

Expense.

24) This plan does not cover services or materials that are cosmetic.

25) This plan does not cover any procedure not listed on the Schedule of Eye Care Services.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	***PLAN MAXIMUM COVERED EXPENSE***	
	Participating Provider	*Non-Participating Provider*
Eye Exam	Covered in Full	Up to $ 52.00
(All lenses are per pair)		
Single Vision Lenses	Covered in Full	Up to $ 55.00
Lined Bifocal Lenses	Covered in Full	Up to $ 75.00
Lined Trifocal Lenses	Covered in Full	Up to $ 95.00
Lenticular Lenses	Covered in Full	Up to $125.00
Frame	Up to $120.00	Up to $ 45.00
Contact Lenses*		
Elective	Up to $120.00	Up to $105.00
Medically Necessary	Covered in Full	Up to $210.00

An Insured can receive professional services for treatment of severe visual problems. A treating provider may prescribe Low Vision treatment. This treatment is for problems that are not correctable with regular lenses. The treating provider determines if the Insured meets the criterion for coverage of this benefit.

*The contact lenses allowance applies to the contact lens exam and lenses.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of one and one-half percent per month on benefits for valid claims not paid within 30 days until the claim is settled. If we do not pay benefits when due, the Insured may bring legal action to recover benefits, interest and any other damages allowable by law.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured unless otherwise agreed upon through your authorization or provider contracts.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.